A bioethical analysis of sexual reorientation interventions.

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A Bioethical Analysis of Sexual Reorientation Interventions

Submitted by:

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Declarations and Statements

Declaration

This work has not been previously accepted in substance for any degrees and is not being concurrently submitted in candidature for any degree.

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31 July 2003

Date

Statement 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Travis K. Svensson, MD, MPH, MRCGP

31 July 2003

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Statement 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organizations.

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Summary of Thesis

The efficacy, consequences and ethical principles surrounding sexual reorientation therapies provided by health professionals has been debated in the public, professional and academic arenas since the first interventions were offered. This thesis applies a model for problem solving in bioethics to the issues raised by this debate. This in depth exploration of the facts and fictions surrounding the provision of sexual reorientation interventions through the critical lens of bioethics will be useful to those patients, health professionals, and health policy makers who struggle to make sense of a highly political health care issue. Sexual reorientation is fraught with conflicting moral and ethical implications that impact the patient and the health professional on many levels. Bioethics is used to bring some clarity to a complex and contentious problem.

Table of Contents

Introduction

The past, present, and future of sexual reorientation interventions by health professionals raise numerous ethical issues warranting critical analysis. Science and medicine have concerned themselves since the late nineteenth century with understanding and manipulating both sexual orientation and behavior. Sexual orientation research continues to receive considerable attention within the medical, mental health, philosophical, gay, lesbian, feminist, and queer[1] areas of Western academia.

Sexual reorientation interventions include efforts to modify an individual's sexual orientation or behavior through scientific, psychological, or medical means. Although primarily geared toward homosexual to heterosexual redirection other goals of treatment can be: to sustain an increased level of heterosexual activity; to eliminate sexual orientation toward children or to diminish fetishes such as stimulation deriving primarily from body parts, erotic toys or other inanimate objects.

Fortunately, many of the interventions employed in the late nineteenth and early twentieth centuries would today be considered unethical. This can be attributed not only to advances in the fields of science, psychology, and medicine but also to changes in the cultural, political, and religious landscape of twentieth century Western society.

First as a medical student, later as a physician and for many years now as a practicing psychiatrist, I have witnessed this phenomenon. The institutions that academically or clinically define Western sexual custom and its derivations have issued numerous policy statements and ethical guides regarding the diagnoses and treatment of sexual orientation over the past twenty years. Such groups as: the American Psychiatric Association; the American Psychological Association; the American Psychoanalytic Association; the National Association of Social Workers (U.S.A.); the American Counselors' Association; the American Academy of Pediatrics and the American Academy of Family Physicians have not only provoked confusion within the lay community by the inconsistent and frequently contradictory stances each has presented but these professional bodies have also created a problematic setting for individual practitioners seeking authoritative guidance in patient treatment.

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[1]Queer in academic circles has come to refer to socially marginalized sexuality.

Within the literature of medicine and psychology, some of the ethical issues surrounding sexual reorientation are raised, but are often not critically analyzed. Within the literature of gay, lesbian, and queer studies - as is also the case with most of the medical and psychological literature - ethical issues are often raised only insofar as they support large political goals or specific agendas. The future of sexual reorientation interventions in medicine is far from certain. With the recent mapping of the human genome, advances in neuropsychopharmacology and genetic pharmaceuticals, as well as increased access to reliable prenatal testing and screening, it becomes clear that our understanding of human sexuality will change dramatically throughout the twenty-first century and beyond. The future promises a much clearer and more scientific understanding of the origins and determinants of sexual orientation. As our understanding grows, it is reasonable to assume that the efficacy of sexual reorientation interventions will do likewise.

Changes in medical practice (whether from the past to present or from the present to the future) cannot help but influence profoundly the way in which ethical issues surrounding sexual orientation interventions are formulated, whether the individual ethics of the patient-physician interaction or the communal ethics of policy development and community standards of care (Loewy, 1996). Loewy asserts that learning about the ethics of yesterday and considering ethics as they are expressed in various cultures today can help to both predict and shape the ethics of tomorrow. Given what the future is likely to hold for the field of human sexuality and our understanding of sexual orientation, it seems prudent to consider tomorrow's ethics today.

Section I: ETHICS

Medicine and ethics are inextricably tied to each other by virtue of the unique relationship between physician and patient. This section examines health care ethics and bioethics.

Chapter 1: A Methodology for Ethical Analysis

In 4th century BC Hippocrates' oath enabled the development of medicine. With the creation of his code of ethics, Hippocrates steered the superstition-riddled art of healing into real science. His ethical guidelines of observation, diagnosis and treatment eventually overruled blame of the gods for illness. Today medical ethics still derive from the Hippocratic precepts.

Bioethics is the 20th century descendant of Hippocratic ideas. Van Rensselaer Potter, an American biologist, is described by Calahan as first to use the term 'bioethics', in his text *Morals and Medicine,* which was published by the theologian Joseph Fletcher in 1954 (Calahan, 1997). Calahan describes the focus of traditional medical ethics as being the expected professional standards of the physician within the doctor-patient relationship. Bioethics, however, has come to refer to the broader field of all the Life Sciences, encompassing medicine, biology, and some aspects of the environmental, population and social sciences. Calahan notes that, while earlier medical ethics focused on the domain of physicians (although with considerable reference to theological interests) bioethics encompasses the work of many disciplines. After its inception in the 1950s, bioethics accelerated development in the 1960s and by the 1970s had begun to assume worldwide importance (Calahan, 1997). This thesis will examine the issues of the medical ethics surrounding sexual reorientation interventions from the broader perspective of bioethics.

The dramatic biotechnological advances in the 1960s fostered growth in the new field. According to Calahan, small groups of professionals and lay people (particularly in Great Britain and the United States) began focusing on the emergent morals during that period.

By the end of the 1970s, bioethics had spread to all the developed nations of the world. In addition to the variety of private and university efforts, various government agencies and commissions have been formed over the past two decades to help set public policy and educate the general public (Calahan, 1997). By the 1990s, bioethics was established as a strong force in the Life Sciences and in general policy deliberations (Calahan, 1997). This thesis will examine the issues of the medical ethics surrounding sexual reorientation interventions from the broader terrain of a bioethics perspective.

Scientific methods that can be reviewed retrospectively from a bioethical perspective were applied in an organized exploration of human sexuality during the middle and late nineteenth

century. Many intervention practices were developed, some of which exist today. Initial medical ethics issues arose from the importance of the doctor-patient relationship and took the form of issues surrounding consent and confidentiality as regarded specific medical concerns. Social, political, and theological sexual orientation ethics were not viewed by the medical establishment as relevant to the ethics of the doctor-patient relationship. Prior to this surge of interest, sexuality was considered to be in the realm of theology and politics as much as medicine. The realm of bioethics could encompass much more in the field of human sexuality.

The evolution of human sexuality into a subject for medical and scientific investigation and intervention occurred at a time when social and political views surrounding gender and sexuality were - as they continue to be - in a state of conflicted transition. The twentieth century saw a dramatic shift in Western politics and societal views towards issues such as equality and the rights afforded an individual on the grounds of gender, race, or membership in a socially marginalized group, as well as the balance between individual autonomy and societal morals. Many academic fields, with a rich and varied collection of philosophies, have emerged during the course of the last century to organize and understand the changing value system of the West. Cultural diversity, feminism, and queer theory originate from a variety of fields including philosophy, anthropology, sociology, psychology, political science, and literature, all of which comment on sexuality and the evolution of the Western value system in the last century. Bioethics is the discipline that integrates these philosophical systems with health care and health science, providing discussion and direction for patients and health professionals.

Ethical Systems

Regarding the development of what would become the bioethics model, Boyd (1997) asserts that traditional ethical codes (from ancient to modern) derive authority from custom, the commands of the gods, or the leaders of the group. He notes, though, that such codes do not necessarily reflect a coherent set of principles. Boyd further observes that in the evolution of ethics, various precepts may not have been consistent, either internally or systemically. Boyd describes the core philosophy as defending traditional authority (e.g. by arguing that it

embodies self-evident moral intuitions) in constructing more coherent foundations for morality. According to Boyd:

> ... philosophical systems of ethics tend to focus either on achieving what is considered to be good (consequentialist or eudeomonistic systems) or on achieving what is considered to be right (deontological systems). The highest human good (if such a thing can be said to exist per se) has generally been considered to be happiness. This can be interpreted, in hedonistic systems, as pleasure (and the avoidance of pain), either for the individual, or for everyone (or the greatest number possible), in utilitarian systems. Both hedonistic and utilitarian systems are consequentialist. Happiness can also be interpreted eudeomonistically, as the kind of human flourishing that involves the realization of one's highest ideals, finding the golden mean and living in harmony with others and one's deepest self. Variations on this theme are found in ethical systems from Confucius, Plato, and Aristotle to Jung and modern virtue ethics. A key tenet is that being determines action - you do what you are; a good person who flourishes has clear moral vision and is disposed to act accordingly. (Nobody does wrong willingly - Socrates; The just man justices - G. M. HOPKINS). Agapeistic ethics is similar (Love God, and what you will do - St. Augustine). Kant's deontological ethical system, based on the moral law within, has affinities with the above, but sees a need to spell moral law out in axioms with which (because of their clear implications for everyone) one must reasonably agree, and on which duties and rights can be based. Reason played a similar role in Spinoza's system, albeit with a more positive emphasis on the emotions. Agreement on principles and procedures is also central to ethical systems that reach it from the consideration of historical or hypothetical contracts among equals (John Rawls' system of justice or fairness is a notable contemporary example) (pp.102-103).

In modern bioethics, the most familiar ethical system is still the deontological -- the root of ethics--which is centered around the four principles of *beneficence, non-maleficence*, and respect for *autonomy* and *justice*. However, determining the scope of their applications requires recourse to consequentialist or eudaemonistic considerations. In applied ethics generally, each type of system has valid insights to contribute. The same can be said of skeptics since the days of Hume, and for existentialists, when they question the objectivity of all such systems. No one ethical system commands universal agreement, but each contributes pertinent questions to the moral spectrum to which reason must be applied before reaching a judgement (p.104). Clearly Boyd is citing a need for a broader ethical tool than traditional medical ethics.

A Framework for Ethical Analysis

Although unproblematic moral issues can reasonably be detected within a situation at first glance, in contemporary health care they are usually forced center-stage because of conflict, actual or anticipated, leading to discussion (Higgs, 1997). Unlike most scenarios in which it is usually up to the individual patient or clinician to initiate an ethical discussion, the subject of sexual reorientation has generated commentary from a diverse range of philosophers, professional groups, political groups, and theologians. Institutions often engage professionals with philosophical expertise to stimulate and shape the discussion of complex ethical issues. However, the subject of sexual reorientation appears to generate critical commentary from very divergent groups, all of which have strong opinions and little interest in discussion.

This thesis follows the framework presented by Campbell and Higgs (1982) for the organization of an ethical analysis at the systems level. Campbell and Higgs examine two principlist models for ethical analysis for each clinical scenario. The Campbell and Higgs model is summarized as follows:

- Identification of the issues at stake, whom they effect, and in what way.
- Further exploration of morally relevant facts with a reasonable attempt to assess the perspectives and purposes of all involved.
- Clarification of the concepts and arguments used in interaction and dialogue in order to air feelings, share points of view, and make sure that everyone is heard.
- An analytical synthesis of the different points of view and concomitant arguments in order to create a response or way forward.

Campbell and Higgs note that a number of additional questions may need to be asked, including:

- Whether the person or group that stimulates the debate is actually the one with the problem?
- Whose point of view has been least heard (whether of a group or an individual) and what this group or individual might say?
- What role individuals played, who they are working for, or what 'system' they were actually involved in?
- Whether any person or group was distorting the discussion by manipulation, misuse of language, or distortion of concepts and arguments?

The flow of such debate depends on the circumstances, especially with respect to whether they are real and immediate (as in the clinical problem) or theoretical and extendable

(as in the philosophical or educational setting) (Higgs, 1997). The field of sexual reorientation includes both varieties, which will be explored further.

Chapter 2: The Stakeholders and their Issues

The first step towards an organized exploration of an ethical conundrum requires not only the identification of the issues at stake but whom they effect and how. This chapter examines the specific medical ethics and bioethics issues surrounding sexual reorientation interventions from the perspective of those groups involved and those who report they speak on behalf of those involved.

The issues identified in this chapter are derived from a series of small group discussions and web-based discussion groups conducted between 1999 and 2001. These discussions focused on both the ethical and bioethical issues surrounding our topic, as well as a review of popular and academic literatures. The following groups have been identified as having a stake in sexual reorientation interventions:

- Gay, lesbian, and bisexual (lesbigay) adults.
- Lesbigay adolescents.
- Non-heterosexual non-lesbigay adults.
- Non-heterosexual non-lesbigay adolescents.
- Gender-identity disordered children.
- Parents and potential parents.
- Healthcare providers.
- Non-healthcare and religious providers.
- Non-heterosexual political activists.
- Professional organizations for health providers.

Gay, Lesbian and Bisexual (Lesbigay) Adults

Lesbigay adults constitute individuals over the age of majority who identify (at least to themselves) as gay, lesbian, or bisexual. Irrespective of whether their status is out, they are associated with their sexual orientation behaviorally or psychologically and have little or no interest in changing their sexual orientation or behavior at the present time. This group engages the health care system because of health concerns arising from sexual behavior (venereal infections and infestation, hepatitis, and the risk of contracting HIV, etc.) or because of emotional difficulties arising from coming out or because of relational issues.

Lesbigay adults report they are best served by the clinician who can discuss issues relating to sexuality without prejudice and without the application of pressure to change orientation or unsafe behavior. When members of this group are encouraged by a clinician to change their behavior or sexual orientation, they often experience the suggestion as homophobic, prejudiced, or bigoted.

A direct contrast to sexual reorientation interventions, gay-affirming psychotherapy is the preferred approach by this group of adults. Self directed (internalized) homophobia is viewed by therapists practicing gay affirming psychotherapy as central to the coming out crisis. It has been postulated that homophobic self-loathing often persists after coming out and persistent, internalized homophobia accounts for recurring depression and addictive disorders.

Several gay and lesbian writers of the late twentieth century have argued that sexual reorientation interventions implicitly or overtly reinforce homophobic views within society. These writers postulate that false beliefs such as "sexual orientation is a choice and that behavior can be reformed accordingly" and "non-heterosexuality is an illness or disease" are the precepts of such interventions. They level at professionals providing sexual reorientation the accusation of perpetuation of prejudice in society and loathing within the self of both *closeted* and out non-heterosexuals.

Gay and lesbian politics in America provides an inescapable backdrop for theories of sexual reorientation. The political movement began by bucking a societal framework that viewed non-heterosexual behavior as sin. Christian values of the nineteenth and twentieth centuries emphasized man's freedom to choose either vice or virtue, with a clear identification of non-heterosexual behavior as unnatural and wicked. It remains commonplace for regional and local governments in America to legislate punishment for marginal sexual activity. Early gay and lesbian politicians fought against a society that criminalizes non-heterosexual behavior.

Early non-heterosexual political groups did oppose medicine's depiction of non-heterosexual behavior as constituting pathology. They countered that if non-heterosexual behavior is the result of a medical or psychological disorder, then an enlightened society should respond with research and treatment, not punishment and social excommunication. The consequence of choosing the label of 'medically ill' over the label of 'morally despicable' however was that gays and lesbians believed themselves 'diseased' and

'disordered'. As heterosexuals began to shift their view of homosexuals from morally ill to medically ill at least the interest in punishing homosexuals began to wane.

Gays, lesbians and bisexuals, as well as other non-heterosexuals have at times been actively coerced into sexual reorientation interventions by clinicians that promised relief from a variety of nervous and mental conditions following the resumption or adoption of a 'normal' sexual orientation. In the past non-heterosexual behaviors or orientations were viewed by most clinicians as de facto evidence of a mental disorder.

In earlier times, some institutionalized adult patients were forced into participating in sexual reorientation interventions. Today, coerced and involuntary treatment of adults is contraindicated by the bioethical principle of respect for autonomy and, in most communities, legal statutes or legal precedence. In most cases, to override patient autonomy a clinician must demonstrate a medical or psychiatric emergency involving imminent serious risk to oneself or others. Sexual orientation may precipitate a patient crisis although alone it rarely, if ever, produces ~~such~~ imminent danger.

There are no 'emergent' sexual reorientation interventions currently available, although the future may bring biotechnology that could permanently or temporarily reorient an individual's sexual orientation with a subsequent marked change in their sexual behavior. Gays, lesbians, and bisexuals reasonably fear that, were such biotechnology to become available, it would be used aggressively to destroy their culture and institutions by a homophobic social majority. The hearing-impaired community has recently become embroiled in a similar discussion generated by biotechnological developments used to restore hearing and speech to children who would have previously been taught sign language to communicate. To the hearing parents of such children, the question of whether or not to make this biotechnology available is uncontroversial, but to the hearing-impaired parents of such children, the prospect of using biotechnology to restore hearing and speech can be problematic. The hearing-impaired community has expressed concern that such technology will result in the slow death of their culture as the numbers of hearing-impaired individuals in the population dwindle.

Lesbigay Adolescents

A less visible but even more vulnerable group invested in this issue are adolescents aware of their sexual orientation and identifying to self or others as gay, lesbian or bisexual. The most

significant problem for them is that, despite their awareness of their own sexual orientation and their identification with gay and lesbian cultures, parents, guardians, and other adults in the community wield control over their lives to varying degrees, depending on the cultural and social environment.

It is no longer uncommon for adolescents to 'come out of the closet' prior to their first sexual encounter. Recently, a thirteen year old boy made the newspaper headlines and evening news in Marin, California when he 'came out' to his family and classmates at school. More often, adolescents are 'out' initially with select peers but remain 'closeted' with their family until they have left home. Others may delay 'coming out' until during or after their college education, or once their career path is well established. The route chosen by the adolescent or young adult often reflects their personality as well as the environment in which they find themselves (tolerant vs. hostile).

Numerous accounts have been published about an 'underground railroad' of runaway teens who make their way to San Francisco and Los Angeles to hide out in 'safe houses' until they are of the age of majority, in order to avoid being returned to parents or institutions that are openly hostile towards the youth's lesbigay identity. Many are reported to have escaped from long-term treatment facilities where they were forced to participate in sexual reorientation interventions.

Barbara Walters of ABC News and Dateline fame popularized the plight of these teenagers in a one hour, prime-time documentary that ran twice in two consecutive seasons (ABC News 20/20; 1996, 1997). Ms. Walters interviewed a young lesbian who, upon coming out, was forced by her mother into long-term residential psychiatric care. The young woman describes in graphic detail a reorientation intervention composed of repeated exposure to pornography coupled with electric shocks. She eventually escaped from the institution, became a runaway, relocated to San Francisco and successfully convinced a court to have her mother removed as guardian to ensure that she would never be institutionalized and subjected to sexual reorientation therapy against her will again.

Nations, states, regions, and communities vary considerably with respect to the amount of control adolescents retain over their sexuality. The case popularized by Barbara Walters highlights the fact that, despite local laws, parents can often find ways to circumvent liberal

community standards by moving the child or adolescent to another locale that gives the parent almost limitless power and authority over them.

The American Academy of Pediatricians and the American Academy of Family Physicians have both issued policy statements condemning the use of sexual reorientation interventions with minors. Despite their clinical power and the reverberations on the psyche of the patient and society these policy statements carry little or no legal weight.

The gay and lesbian community as advocates for gay, lesbian and bisexual youth view the availability of any sexual reorientation interventions to adult patients as a potentially problematic because of the potential for inappropriate application to children and adolescents. The defenders have also argued that, even if it were illegal or deemed unethical for health providers to employ sexual reorientation interventions with children or adolescents, it would remain likely that some religious groups would continue to use the techniques to try to extinguish non-heterosexual thoughts and behavior from children and adolescents in their congregations.

If biotechnology looms as a real or potentially real threat to these young people and the risk of being forced into treatment increases, so shall the anxieties associated with 'coming out' and therefore burden the child with more reasons for remaining closeted.

It is good that the last decade in America brought the establishment of gay-affirming community resources for non-heterosexual youth in most larger metropolitan areas. Many college and university campuses also now have resources for non-heterosexual youth ~~to~~ dealing with sexual identity and coming out issues.

Non-heterosexual Non-lesbigay Adults

This is the group of adults that recognizes its own non-heterosexual orientations and/or behavior patterns, but identifies as other than gay, lesbian or bisexual. Unlike the closeted lesbigay, members of this group do not necessarily view their sexuality as personally acceptable or fulfilling. They often invert homophobia towards themselves and display it overtly towards others. Often this group would choose heterosexuality as their orientation and behavior if the choice were readily available. Also often, these people subscribe to strong religious or cultural values and assess the appropriateness of their desire and behavior accordingly. They may fully resolve the conflicts between their individual sexuality and their

cultural and religious expectations themselves, or the conflicts may smolder for years and ultimately either die quietly or erupt in crisis.

Members of this group may engage the medical system or their religious system when in crisis, or the unresolved issues may come to the surface in the course of dealing with an unrelated problem. While gay-affirming therapists are likely to view strong attachment to religious or cultural values as a symptom of internalized homophobia, counseling or reorientation interventions with a religious basis rarely acknowledge the existence of such. The optimal referral for these patients would seem to be the 'neutral' counselor or therapist who can facilitate a process of self-exploration and self-discovery without overtly or covertly substituting the therapist's value system for the patient's. Following a thorough assessment, the neutral therapist or counselor should be in a position to refer the non-heterosexual non-lesbigay patient to either a gay-affirming mental health resource or for sexual reorientation intervention as indicated by the individual patient's needs and desires.

Unfortunately, therapists and counselors cannot always achieve neutrality with respect to patient values and morals. Some subscribe to the theory that neutrality is harmful and contraindicated. While others formulate it as an unattainable ideal and miss the opportunity of trying it. A few erroneously believe that they bring such neutrality to every encounter.

Professional organizations develop policy statements and ethical guides in part to facilitate practitioners in having good boundaries when dealing with controversial, value-laden subject matter. Recently published professional guidelines clearly favor gay-affirming interventions over sexual reorientation interventions and often fail to address the needs of those patients who do not desire to develop a gay or lesbian identity, beyond offering them counseling and therapy intended to change their decision.

Options for this population are limited. Community resources for the non-heterosexual with identity issues tend to be funded either by lesbigay or religious groups and so the advice available tends to be colored by the values of the funding group. Many community resources are housed or affiliated with what would appear to be relatively value-neutral institutions such as schools, colleges, and municipal departments. However, on deeper scrutiny these resources often offer advice that is strongly slanted towards a particular view of sexual orientation and identity. The website of a prominent state university in the American Midwest reports that current sexual reorientation interventions include brain surgery,

prefrontal lobotomy and electroshock treatments. In actuality, nowhere in America do any physicians or hospitals perform brain surgery, lobotomies or electroconvulsive therapy for sexual reorientation.

Non-heterosexual Non-lesbigay Adolescents

This group is composed of adolescents who recognize their non-heterosexual orientations and/or behavior patterns, but choose not to identify as gay, lesbian, or bisexual. Unlike the closeted lesbigay adolescent, members of this group do not view their sexuality as personally acceptable or fulfilling, often display overt homophobia towards themselves and others, and would choose heterosexuality as their orientation and behavior if the choice were readily available.

These adolescents share the same difficulty in accessing value-neutral resources as non-lesbigay non-heterosexual adults. The lesbigay community views this group's heterosexist value system as both morally and intellectually weak and assumes it to be strongly tied to internalized homophobia, which must be exorcised. In the absence of access to lesbigay resources, these adolescents must look to religious groups and the mental health system for assistance with sexual identity issues, or abandon their heterosexist value system.

As with lesbigay adolescents, members of this group often struggle to decide to whom and at what time they will share information about their sexual orientation. Some will eventually abandon or modify their value system so as to tolerate or even embrace a lesbigay identity. For many in the arenas of mental health and academia this is assumed to be the natural evolution of a lesbigay identity. It is presumed that *all* lesbigays start out as non-heterosexual non-lesbigay heterosexists and evolve through the 'coming out' process to establish a lesbian, gay, or bisexual identity. Of course, the view that non-lesbigay non-heterosexual identity is simply arrested or incomplete lesbigay identity development sounds remarkably like the Freudian theory that hypothesizes homosexual orientation as just arrested or incomplete heterosexual orientation development (Freud, 1962).

It is the non-heterosexual non-lesbigay adult and adolescent population that is most inclined to seek out sexual reorientation interventions voluntarily. Currently, reorientation interventions are available from select mental health practitioners and certain religious groups. The process of making an informed clinical decision is complicated by an

overwhelming amount of political and religious propaganda masquerading as scientific data. While the adult can readily investigate the options for sexual reorientation and seek out assistance from religious and mental health professionals in making informed clinical decisions, the adolescent often has the additional burden of disclosure to parents prior to obtaining the assistance they seek. Also burdensome is that the American Academy of Pediatrics and the American Academy of Family Physicians have specifically opposed sexual reorientation interventions, thus making a request for referral from the adolescent's primary care provider likely to be ignored (AAP, 1993; AAFP, 1994). It is notable that neither organization comments on the ethics or morality of gay-affirming psychotherapies.

Gender Identity Disordered Children

Gender-identity disordered children are considered by many medical as well as lay individuals to be 'pre-homosexual', and indeed there is some evidence that gender-identity disorder in children is associated with an increased incidence of homosexual orientation in adolescence and adulthood. Gender dysphoria, both in children and adults, warrants treatment by the mental health system with the goal of improving the patient's quality of life. Treatment of gender-identity disordered children for the purpose of preventing subsequent homosexual orientation has questionable clinical motives.

Children with gender-identity disorders may or may not be distressed by their identity. When a disordered gender-identity creates or perpetuates emotional distress, or impairs social functioning, it is universally considered clinically appropriate to intervene (Nicolosi, 1991). However, intervention with a child solely for the purpose of preventing homosexual orientation later in life raises many questions.

As children are not expected to participate in the informed consent process, consent falls to parents or guardians. Health providers must raise the issue of the 'goal' of therapy with GID children. When intervention continues despite normalized mood and social functioning, the goals of treatment become an ethical issue. Interventions applied to children with the intention of preventing non-heterosexual behaviors or orientations in adolescence or adulthood have not been specifically addressed by professional organizations, but sexual reorientation interventions in adolescents (both voluntary and involuntary) have been

condemned by the American Academy of Pediatrics and the American Academy of Family Physicians (AAP, 1993; AAFP, 1994).

The prevention of homosexuality through intervention with gender disordered children resembles in many ways the issue of restoring hearing to children who would normally be deaf, and learn sign language and lip reading as members of the deaf community. However, only a small percentage of adult homosexuals would have met the diagnostic criteria for gender-identity disorder during childhood. Clearly, even if all gender disordered children were successfully treated to prevent future homosexuality, the impact on the number of adult homosexuals would be minimal. The argument that such interventions are equivalent to genocide perpetrated against homosexuals appears to be exaggerated.

There are some similarities between the status of homosexuals in Western culture and that of women in India. Given the low social status of women and undesirability of daughters, the abortion of female fetuses has grown commonplace. Prenatal ultrasounds to determine the sex of the fetus in order to facilitate the abortion of daughters were outlawed in several Indian states as a step towards improving the status of women. The rationale for this decision is two-fold: if men substantially outnumber women, the status of women will never improve, and a society that allows the destruction of females in utero must tacitly endorse the unacceptably low social status of women in society, and be an active agent against change (Weeks, 1977).

These arguments have also been applied to the situation of Western homosexuals. It has been said that a society that permits the prevention of homosexuality or reorientation of non-heterosexuals must tacitly support the lower social status of non-heterosexuals (Weeks, 1977). Minimizing the percentage of non-heterosexuals in a society through prevention and reorientation directly decreases the power that non-heterosexuals can exert, perpetuating a heterosexist *status quo*.

It is conceivable that there may be prenatal screening technology in the future to predict sexual orientation. If and when such technology becomes available, its use in conjunction with abortion might have the effect of eliminating non-heterosexual behavior and orientation in the upper and middle classes of society (the groups most likely to afford and participate in prenatal screening) resulting in economic discrimination against non-heterosexuals. Were prenatal or neonatal screening able to predict future non-heterosexual orientation or behavior once the time limit for safe abortion had passed, children that screen positive for being at risk

might receive very different upbringings - either intentionally or unintentionally - resulting in unpredictable outcomes. Similarly, there are those who object to screening and subsequent abortion for disabilities on the grounds that the process devalues those already living with the condition.

Parents and Potential Parents

Parents of children and adolescents must make clinically informed medical decisions. Access to consultation and referrals for sexual reorientation may be withheld by primary care providers, according to the stated positions of the American Academy of Pediatrics and the American Academy of Family Physicians (AAP, 1993; AAFP, 1994). In some regions, consultation may only be available through religious organizations. It seems likely that parents will weigh the emotional and social burdens of potential or evident non-heterosexual orientation in their children and decide that prevention or reorientation is appropriate. This decision occurs most often when the family or parents are strongly tied to heterosexist religious or cultural values. Such parents may find an erosion of their control over the sexual lives of their children. The fact that the American Academy of Pediatrics and the American Academy of Family Physicians has come out against sexual reorientation interventions with adolescents may mark the beginning of a trend whereby policy makers actively address issues of parental consent and control over the sexual destiny of adolescents - a trend already in process, as a result of the debate over adolescent access to birth control and abortion.

The case popularized by Barbara Walters (1995, 1996) is an example of how regional politics can register markedly different views towards the role of the parent in controlling the sexual orientation of an adolescent or child. In southern California (Los Angeles), the parent in question was well within her rights in sending the dependent adolescent to another state (Utah) for institution-based residential treatment of depression and sexual identity dysphoria. In northern California (San Francisco), the dependent adolescent succeeded in divorcing herself from her parent on the basis of irreconcilable differences surrounding her sexual orientation.

Technology currently allows parents to determine the sex of their unborn offspring with the option of terminating those of the undesired sex. It is possible that prenatal testing could

one day predict an increased risk for non-heterosexual offspring either in utero or in early life. The consequences of such technology could include:

- Heterosexual parents could choose heterosexual offspring and homosexual parents could choose homosexual offspring.
- Parents with strong heterosexist values could abort homosexual offspring.
- Offspring with ambiguous futures could be 'conditioned' towards one orientation or the other through the manipulation of environmental factors and parenting style.
- Pre-homosexual children could be prepared for the hardships that await them, by strengthening their self-confidence and self-esteem in preparation for a potentially hostile environment.

All such potential outcomes create significant ethical issues for individual parents and for society as a whole. As mentioned above, were such technology to become available, it would probably be used first by the upper and middle classes of affluent Western societies. Currently, non-heterosexual behavior and orientation appears to occur throughout all races and social classes, but the technology described above could significantly distort the distribution of non-heterosexual behavior and orientation in the future with the consequence of marginalizing non-heterosexuals still further.

Healthcare Providers

Since the early 1970s, gay and lesbian politics have been a very active force within the groups responsible for policy making for mental health professional groups in America. Within Western medicine (and society in general), non-heterosexual behavior has evolved slowly but steadily over the last century from sin/vice to illness/compulsion to representative of a healthy social and biological minority.

With the removal of homosexuality from the *Diagnostic and Statistical Manual* (*DSM*) of the American Psychiatric Association, many gay and lesbian groups have taken the position that since homosexuality is not an illness or disease it is inappropriate to offer treatment. Similarly, the same groups often assume that if a patient seeks treatment it is because they have been led to believe that they are 'sick', 'diseased', or 'disordered'.

Caregivers may be biased as well. There are still many mental health professionals who consider that almost all non-heterosexual behavior or orientation in adulthood originates from

psychosexual developmental milestones in childhood. Many subscribe to the notion that when these connections exist from childhood to adulthood, psychotherapeutic intervention is potentially useful. Similarly, there are some within the mental health professions who view most non-heterosexual behavior as genetically or biologically driven and thus relatively resistant to modification or change through psychotherapeutic interventions. The majority has adopted the view that non-heterosexual behaviors and orientations originate from a variety of potential factors including biology, genetics, environment, and psychosocial and psychosexual developmental events. Only a small minority of American mental health professionals report routinely providing sexual reorientation therapy or interventions as part of their practice. Most believe that these interventions are expensive and time-consuming and offer only limited potential for short-term, partial success for a condition that is not even a "medical illness."

Health care providers who are engaged in research as to the origins of non-heterosexual orientations and behavior have come under attack by gay and lesbian philosophers and politicos. It has been suggested that any research into reorientation interventions and the origins of sexual orientation or futuristic biotechnologies related to sexual orientation is unethical. Some have questioned the process of informed consent for patients engaged in research or treatment for sexual reorientation, with the assertion that if the patients were fully informed, few would choose sexual reorientation interventions. Similarly, the ethics of health care providers have been questioned on the premise that it is unethical to offer treatments that are expensive, show only modest success rates and are associated with a risk of depression and anxiety about a state or condition that is not an illness, disease or disorder. Health care providers, and in particular mental health care providers, must resolve many of the following ethical dilemmas: "Is the process of informed consent different for sexual reorientation than for other procedures and interventions?" "Is the informed consent process different with sexual reorientation intervention for children and adolescents than for other procedures and interventions offered to this group?" "Is a provider unethical if he provides sexual reorientation interventions to adolescents despite prohibitive recommendations by the American Academy of Pediatrics and the American Academy of Family Physicians?" "To what extent do the provider's personal opinions and values regarding non-heterosexual orientations and behavior impact how the provider deals with patients?"

Over the years, health care providers in America have fallen victim to terrorist tactics and assassination by radical anti-abortionists. If future biotechnological advances include abortion for pre-homosexual fetuses or allow parents to select homosexual offspring in utero or before fertilization, health care providers might again find themselves the target of terrorists and radical political and religious groups. The ethics of how a provider proceeds in the face of such risks to self and to patients is pertinent to this discussion.

Non-Health Care Providers and Religious Groups

The services offered by religious groups have long overlapped those provided by mental health professionals. Examples include bereavement support, marriage and couple counseling, premarital counseling, and child rearing and parenting support. Because of the long-established tradition of a separation of church and state in America, few if any civil authorities or professional groups from within health care comment on the extent or content of such interactions. There is a small number of care providers with formal training in one of the mental health or medical disciplines as well as in divinity or theology, or with the skills necessary to work as chaplains. An even smaller group of health care providers is trained in a program specifically designed to integrate studies in psychology or counseling with theology or divinity. The professional ethics of providers with formal training in one of the mental health or medical fields is addressed by both legislation and policy statements on the part of professional groups appropriate to their training.

The Ex-Gay movement exploded onto the public scene in America in 1996 and peaked in popularity in 1998. At that time, it included a network of 300 or more church groups across America offering a variety of strategies designed to help gays and lesbians to change their sexual orientation through prayer, scripture, attending support groups, and undergoing psychological and pseudo-psychological interventions. A nation-wide advertising campaign was launched to recruit non-heterosexuals into the movement and was followed by a mixed response in the general press and a vocal negative response from gay and lesbian circles.

The formulas for changing from non-heterosexual behavior and identity promoted by the Ex-Gay movement and its 'franchise' affiliates appear to vary considerably, as do the proposed origins of non-heterosexual behaviors and orientations. The two predominant models include:

- The 'sin/vice/addiction' model with interventions such as prayer, abstinence, individual sponsorship and support groups often modeled on the 12 step programs for alcohol and drug addiction.
- The masculine deficit model which emphasizes individual therapy or a mentor that is a strong heterosexual male figure that 're-parents', together with a regime of structured masculine heterosexual activities.

Critics have described the latter intervention strategy as *team sports and hunting therapy.* Those opposed to the Ex-Gay movement emphasize the lack of research to support the effectiveness of the strategies and the risk of escalating untreated anxiety and depression if the subject fails or relapses.

The Ex-Gay phenomenon has had the effect of distancing sexual reorientation from professional health care policy makers and the politics of health care. This results in an increase in the autonomy of providers, possibly to the detriment of the autonomy and safety of participants. Critics question the informed consent process and lack of professional supervision. Some former Ex-Gay participants describe a near cult-like environment, with participants being 'brainwashed' into accepting heterosexuality. Defenders of the Ex-Gay movement emphasize the right of Americans to religious freedom while reporting extremely positive success rates.

The movement of mainstream contemporary medical and mental health professionals away from sexual reorientation interventions occurs at a time when the gay and lesbian cultures are increasingly viewed as an established fixture within contemporary Western society. If gay and lesbian politicos are successful in extinguishing sexual reorientation interventions by medicine or mental health professionals through policy development, legislative developments or ethical proclamations, the practitioners might find themselves in situations similar to that of American abortionists prior to legalization. Likewise, non-heterosexuals in search of reorientation might find themselves having to seek out risky clandestine interventions by poorly trained 'back-street' clinicians or avaricious nonprofessionals.

Non-Heterosexual Political Movement

High profile issues spark high reaction. An organized political movement by gays and lesbians began in the early twentieth century and is still active today. The political movement

for gay men and lesbians has, at times, been completely separate, independent and with divergent goals, and at others integrated and unified in pursuit of a common purpose. The initial goals for the homophile movement (composed of gay men) in America focused on the decriminalization of homosexual behavior (Stein, 1996). To this end, the homophile movement was aggressive in its efforts to perpetuate and disseminate the medical view that homosexuality was a medical (genetic, biological, environmental, and/or psychiatric) condition and not a deficit of morality or character deserving of punishment. The beginnings of a lesbian political movement in America was linked to feminism and the women's rights movement.

By the middle of the twentieth century, homosexual behavior (sodomy) was viewed as a victimless crime and was rarely criminally prosecuted in America, although in many jurisdictions the laws remained on the books. Nonetheless, gays and lesbians continued to be both legally and illegally harassed by law enforcement agencies on the basis of cross-dressing, prostitution, and alcohol related statutes. Meanwhile, women having acquired the right to vote had shifted to a reformulation of gender roles and economic equality (equal pay for equal work).

The 1960s in America were years of great social upheaval. The fight for racial equality took center stage, followed by that for gender equality. Following the moral model used effectively by racial minorities and women, the gay and lesbian political movement abandoned the pathologizing medical model of homosexuality that had successfully decriminalized homosexuality in favor of an equality model. The gay and lesbian movement aggressively and successfully lobbied the American psychiatric community for the removal of homosexuality as a 'diagnostic entity' and simultaneously undertook to teach the American public that homosexuality was not a medical or moral disorder, that gays and lesbians do not prey on children, that gays and lesbians pay taxes, are civic-minded, and entitled to all the benefits and privileges of any other citizen.

HIV and AIDS appeared on the scene in the early 1980s and gay and lesbian politicos focused intensively on crisis management for the remainder of the century. Issues at hand included treatment funding, research funding, testing privacy, civil rights, public education and the prevention of hate crimes and discrimination. The Ex-Gays and the 'moral majority' (conservative Christian right) were viewed as bigoted homophobic movements that directly

opposed the gay and lesbian political agenda, perpetuated self-hatred among non-heterosexuals, and threatened to reverse all the social gains acquired in the last half century for gays and lesbians. In response, the gay, lesbian and bisexual community aggressively lobbied medicine and mental health agencies to oppose and declare unethical any efforts at sexual reorientation.

Medical and Mental Health Professional Organizations

The psychiatric community came under intense political pressure in the early 1970s to remove homosexuality as a diagnosis from the *DSM*, both from within its own organization and from the gay, lesbian and bisexual community. Soon afterwards, the American psychoanalytic community came under scrutiny for policies that discriminated against gay and lesbian professionals in terms of access to training and teaching positions within the field (Stein, 1996).

In response to conservative Christian movements, such as the Moral Majority, Exodus, and Ex-Gays, the gay and lesbian community aggressively lobbied the professional institutions of the American pediatric, family medicine, psychiatry, psychology, social work and counseling vocations throughout the last decade of the twentieth century for a ban on reorientation interventions and a declaration that the providers of sexual reorientation interventions were unethical professionals (NARTH, 1991). All of the professional groups thus lobbied have responded to the political pressure by releasing a range of policy statements, fact sheets, guidelines, declarations, and public service announcements that fall short of the goals of the gay and lesbian community.

NARTH (National Association for Research on Homosexuality and Therapy) is the only professional group specifically established to support the provision of sexual reorientation interventions by mental health professionals. NARTH persistently criticizes the response of the medical and mental health professional organizations to the lobbying of the gay, lesbian and bisexual groups, accusing them of catering to gays and lesbians at the expense of sexual reorientation providers and non-lesbigay non-heterosexuals who seek sexual reorientation.

When widespread and enduring social conflict exists it is often to medicine that people look for guidance. The role of medicine in the initiation and perpetuation of social change is unclear, particularly when public values and morality become involved, and the issues at hand

are not directly related to mortality and health morbidity. Medicine must always listen to the community it serves and adapt itself accordingly to preserve and promote essential public trust essential to the fiduciary relationship between patients and their health providers. However, it is not clear whether organized medicine is prepared to participate as a tool for social change. When considering such a role, organized medicine must listen to the community as a whole and resist being 'used' by one social group to achieve specific political goals at the expense of other groups.

Stakeholder's Principles Summarized:

Autonomy

The bioethical principle of autonomy identifies the fully informed and competent patient as the best decision-maker for himself. The patient (not the provider, health system, socio-political groups, legislature or courts) should be in charge of choosing between available medical treatments and non-medical treatments or no treatment. Policy-makers and political groups should not influence the accessibility of safe and effective interventions for the purpose of socio-political motives or to resolve social injustices. Alternatively, it is argued that because of social, familial, and religious pressures; patients are often unable to be fully autonomous or fully informed on the subject of sexual reorientation. It has been argued that the principle of non-maleficence outweighs patient autonomy, given the increased incidence of shame, depression, and suicide prior to and during sexual reorientation procedures and given the low potential for successful reorientation. It has also been argued by thoase opposed to sexual reorientation that non-maleficence and justice should outweigh misguided patient autonomy. O'Neill's paper on consent more fully explores these issues.

Beneficence

Reorientation to heterosexuality offers multiple positive psychological, social, and health benefits. The individual provider is obligated to assist the patient in the task of weighing the potential risks and benefits of any particular course of action (autonomy) in any given clinical situation. Patients are entitled to pursue legitimate efforts to improve the quality of their lives

(individually and socially), irrespective of the value system of their health providers and their affiliated professional organizations or socio-political movements. Alternatively, it has been argued that the risk of harm (maleficence) far outweighs the potential benefits (beneficence) of sexual reorientation interventions, given the low rates of success. Gay affirming therapies are identified as far safer and more successful at resolving issues of sexual orientation in a way that produces a higher long-term quality of life.

Justice

Health providers must acknowledge and respect patient values even when they contradict or are in opposition to those of the provider or the predominant culture. It is unjust for professional organizations to develop policies that address the needs of one sub-culture in a society at the expense of another. It is unjust for health care policy makers to prioritize one "value-system" over another. Policy makers must allow providers and patients to resolve these issues on an individual basis, as they are too complex for broad sweeping profession or public policies. Alternatively, the mere existence of sexual reorientation interventions within the structure of the health care system has been said to reinforce on a societal level unfounded negative attitudes and false beliefs about non-heterosexuals. It is argued that it is unjust for health care to participate intentionally or unintentionally in the perpetuation of homophobia, homonegativity or heterosexism.

Non-Maleficence

The negative psychological, social and health consequences of non-heterosexuality are argued to be both real and significant. Gay affirming therapies have the goal of increasing a patient's long-term exposure to these risks. The principle of doing no harm has been contrasted with the provision of gay affirming therapies, and the same principle has been used to argue against the provision of sexual reorientation interventions. However, research data has not identified any predictable, long term negative consequences to either successful or unsuccessful gay affirming or sexual reorienting interventions. It has been argued that sexual reorientation reinforces shame and internalizes homophobia and self-loathing within patients,

and that these problems increase when patients are unsuccessful in their attempts to change. It is argued that harmful self-perceptions are reinforced and can produce lasting and profound negative consequences for the individual's psyche.

Locus of Decision Making

The fulcrum for the resolution of complex ethical decisions has traditionally been the bond between the patient and the clinician. This practice has long been in place and is supported by the principles of patient autonomy and competent informed consent. Autonomy must be balanced with provider paternalism. This balance varies dramatically from one situation to another (including cultural factors, health/disease status, competence, risk, and the complexity of the intervention planned). Professional organizations have an established role in monitoring members of the profession, both to insure public safety and to promote the goals and public esteem of the profession itself. It can be problematic when professional organizations work towards their own goals to the detriment of the patient or when professional organizations undertake to promote the goals of one social group over another to the detriment of members of the profession and their patients alike. Courts and legislatures are particularly poorly prepared for managing ethical problems in medicine because decisions often lag behind technology and science and because the needs of the individual are too often lost in balancing political and social objectives.

This discussion of the stakeholders and their issues is concluded with a reminder that many these issues are not supported by evidence. This is in part because the debate on sexual reorientation interventions is largely concerned with values, but also because the values (both personal and political) of researchers and clinicians have dramatically colored the clinical landscape.

Section II: Morally Relevant Facts and Fictions

Much of the debate surrounding sexual reorientation has been public and has drawn on intentionally and unintentionally value laden beliefs and assumptions that at times are hotly contested and at others quietly integrated into the discussion as fact. The chapters in this section explore the factual state of the debate in the twenty-first century as well as the history behind many of the fictions still firmly rooted in our society.

Chapter 3: Homosexual Incidence and Prevalence

Rarely have people been so cruel to their fellows than in condemnation and punishment of those accused of so-called sexual perversion. Penalties have included: imprisonment, torture, the loss of life or limb, banishment, blackmail, social ostracism, the loss of social prestige, renunciation by friends and families, the loss of position in school or business, severe penalties meted out for the convictions of men serving in the armed forces, public condemnation by emotionally insecure and vindictive judges, and the torture endured by those who live in the constant fear that their non-conforming sexual behavior will be exposed to public view. These penalties have been imposed on persons who have done no damage to the property or physical bodies of others, but who have simply failed to conform to mandated custom. Only religious and racial persecutions match such savagery (Kinsey et al, 1948).

The pressure to conform to cultural, religious, familial, and internalized expectations dramatically impacts the accurate assessment of the incidence and prevalence of marginalized sexualities. Yet any discussion of an ethical problem such as sexual reorientation requires that the problem be quantified to demonstrate the impact on the population and health care consumers.

A grasp on the magnitude of homosexual incidence and prevalence is important in order also to place the issues surrounding sexual reorientation in a twenty-first century context. Facts too can diminish the political and social drama that colors public debate. Because issues of sexuality engender such strong emotional response, often required is an effort to reconcile our impression of reality with the facts. This chapter focuses on the data relating to homosexuality that has been collected over the last fifty years. In doing so it brings into stark relief the difficulties encountered in defining, describing, quantifying, and securing a common language for mainstream and marginalized sexuality and illuminates the public debate surrounding sexual reorientation which has often included value-laden exaggerations and misrepresentations.

In 1948, Alfred Kinsey estimated that as many as 40% of all males engaged in homosexual activity in any one year, saying that the judge who considers the case of the male who has been arrested for homosexual activity should keep in mind that nearly 40% of all other males in the town could be arrested for homosexual activity that had taken place within that year

(Kinsey, 1948). His views were immediately attacked by Edmund Bergler (1957), who said that:

> Kinsey's erroneous conclusions pertaining to homosexuality will be politically and propagandistically used against the United States abroad, stigmatizing the nation as a whole in a whisper campaign, especially since there are no comparable statistics available for other countries (p.35).

For many years, it has been widely taught that homosexuality exists in all populations at a steady rate of 10%, as was established by the landmark study by Kinsey et al in 1948. This assertion has come under debate following the appearance of probability surveys of sexual behavior in the Americas and Europe (Michaels, 1996). These surveys, largely undertaken in response to the AIDS crisis, have produced estimates of the prevalence of various measures of homosexuality much lower than those from the famous Kinsey studies (Kinsey et al, 1948, 1953).

Determining the prevalence of homosexuality is not as simple as one might think. Although recent large scale, sophisticated population survey of sexuality (Billy et al, 1993; Catania et al, 1992; Laumann et al, 1994; Spira et al, 1993; Wellings et al, 1994) represents a major advance in the production of prevalence data, a great deal of confusion remains about surveys, what questions they can answer, and how one should interpret the results they provide. As is the case with any social data, there is a substantial risk of manipulation and misrepresentation for the purpose of political and social propaganda.

Behavior and Identity

Distortion of data occurs in many ways. The most direct and efficient way to color any analysis of incidence and prevalence data is to manipulate the definitions used. Current ethical debate is fraught with intentional and unintentional distortion subtly delivered through redefinitions that support political agendas. The words *behavior* and *identity* are not interchangeable yet data on behavior is often presented as data on identity, when the two actually paint very different pictures when used with accurate definitions. Likewise any ethical discussion that includes references to incidence and prevalence must acknowledge the impact of defining and redefining sexuality for quantification and qualification.

The literature observes this. In a discussion of prevalence, Michaels notes another example:

> ... it is important to avoid confusing homosexuality with the notion of the homosexual. The latter is closely tied to the search for a single estimate of the number or proportion of (true or real) homosexual individuals. However, the presumption built into this approach merits careful consideration. It presumes that two clearly delineated groups exist: homosexual persons and non-homosexual persons. Furthermore, it presumes that the distinguishing quality or trait used to classify people is homogenous, both in individual lives and across historical periods. Typically, researchers have used indicators such as the presence or absence of any homosexual experience or exclusive homosexual experience. Although nothing is inherently wrong with this approach, the danger arises when one moves - often quite subtly - from simple and arbitrary operations of grouping to conceptual distinctions between homosexual and non-homosexual individuals as types of persons and from there to the inference of all sorts of other psychological, social, and sexual implications for individuals in one group or another. In response to recent surveys, the media and others have treated measures of homosexual behavior (e.g. any same-gender partners in specific time periods or ever), desire (e.g. any attraction to persons of one's own gender), and identity (e.g. any self-identification as homosexual) as if they were mutually equivalent, and also to the conceptual entity that is the 'homosexual or gay population'. Therefore, in interpreting research results, it is very important to be attentive to what is actually being measured and reported (p.43).

In one of the more creative innovations devised to evaluate prevalence of homosexuality, in the 1960s, psychologist Kurt Freund (1965) invented 'penile plethysmograph.' This instrument measures the changes in penile volume and pressure that occur in response to erotic stimuli, offering scientists a means to quantify sexual arousal directly. A similar device has been developed for women (Sintchak & Geer, 1975). According to Freund (1974), the great majority of men show plethysmographic responses to pictures of naked adult women or to pictures of naked adult men, but very few, if any, were bisexual by plethysmographic criteria. LeVay (1996), however cautions against generalizing from Freund's results because of the lack of broad random sampling of the population. Also, a similar study of women at the University of Amsterdam produced very different results (Laan et al, 1996).

Homosexual demographic evaluation relating to AIDS has supplied new, more accurate information on sex choice prevalence worldwide. Research activities of public health and academia as related to gays, lesbians, and persons living with HIV and AIDS have come under significant social and political scrutiny and therefore often adhere to more stringent standards. An accurate and realistic understanding of sexual behaviors in various populations (high and low risk) is no longer a curious academic exercise but an available and essential

public health tool for the management of an epidemic (Carroll, 1996). Sadly, discussants often quote textbook data several decades old as gospel.

Kinsey and Company

For more than 40 years, the principal data on the prevalence of homosexual activity in the United States were the two volumes written by Kinsey and his colleagues after World War II, *Sexual Behavior in the Human Male* (Kinsey et al, 1948) and *Sexual Behavior in the Human Female* (Kinsey et al, 1953). Kinsey's work is cited as the basis for the widely accepted notion that 10% of the population is homosexual, although Kinsey never reported this and explicitly argued against this type of categorization (Michaels, 1996). Kinsey is by far the most frequently quoted author on the subject of sexual behavior, but by today's standards his works would be considered wanting in scientific rigor. All of Kinsey's respondents were volunteers actively solicited by the researchers with a preponderance of subjects from male-only institutions (prisons, the military, private schools and college) (Gebhard & Johnson, 1979; Kinsey et al, 1948). This process of self-selection and sampling that fails to reflect the larger general population makes Kinsey's data difficult to interpret or extrapolate from.

Kinsey rejected the notion that people were divided into the categories of heterosexual, homosexual, and bisexual. Instead, he believed that *everyone* was capable of both homosexual and heterosexual responses and that individuals should be described in terms of the distribution of their total experiences along a seven-point 'heterosexual-homosexual' continuum, from 0 to 6 (Michaels, 1996). Despite problems with the population sampling, the Kinsey scale profoundly changed the way sexuality was conceptualized for the remainder of the century.

Of the more than 4,000 white men who were studied by Kinsey et al, 37% had had " ... at least some overt homosexual experience to the point of orgasm between adolescence and old age," 25% had had " ... more than incidental homosexual experience or reactions for at least 3 years between the ages of 16 and 55," (values of 2 through 6), 10% were " ... more or less exclusively homosexual for at least 3 years between the ages of 16 and 55" (values 5 and 6) and 4% were "exclusively homosexual throughout their lives, after the onset of adolescence" (value of 6) (Kinsey et al, 1948). In the study on sexual behavior in women, Kinsey et al did not provide as extensive a summary of the data, but did state that rates of homosexuality were

much lower for women - about one-half to one-third of those for men. For example, only 13% of the women had had a sexual experience to orgasm with another woman, in contrast to 37% of men (Kinsey et al, 1953).

Michaels notes that although there is no necessary relationship between prevalence and normality or health in any moral or biological sense, behaviors engaged in by more than one-third of the male population are, at least, common. This finding has often been used to argue for the normality and acceptability of homosexuality (Michaels, 1996). Gebbard, one of Kinsey's main collaborators and the director of the Institute for Sex Research that Kinsey founded, constructed a reasoned estimate that " ... about 4% of ... white college-educated adult males are predominantly homosexual" and that "... in the total adult female population, the incidence of predominantly homosexual individuals is between 1% and 2%, probably nearer 1%" (Gebbard, 1972). Gagnon and Simon (1973) reanalyzed the Kinsey data to show that much of the reported homosexual behavior occurred in adolescence.

Sexology After Kinsey

Although major statistical problems (the lack of a probability-base sample) were authoritatively identified within a few years of the publication of the first Kinsey volume (Cochran et al, 1954), it took a long time for researchers to attempt to replicate and improve on the work of Kinsey et al. Only after the emergence of the AIDS crisis did governments, social scientists, and private foundations begin to become acutely aware of the lack of adequate information about sexual behavior (Institute of Medicine, 1986).

Four decades after the seminal Kinsey work more research was available. A review and comparison of the data from 1988 through 1990 from the General Social Survey (GSS), the 1970 Kinsey Institute study, and a 1989 study of male-male sexual behavior in Dallas was published by Rogers and Turner in 1991. They concluded: "... roughly 5 to 7% of American men 'report' some same-gender sexual contact in adulthood ... that reported prevalence is somewhat higher for men living in urbanized areas. These survey estimates ... are best treated as lower bounds of the actual prevalence of such contact."

Because of AIDS, governments finally got on the bandwagon and, according to Michaels, initiated major surveys of adult sexual behavior in the early 1990's. Only France followed through to completion since conservative governments in Great Britain and the United States

withdrew support for these national surveys, which were then completed with private foundation support (Michaels, 1996). The surveys all used probability samples and, in France and Great Britain, were based on large national samples (20,055 and 18,876 persons, respectively); the American study (Laumann et al, 1994) had a smaller sample (3,432 persons).

Recent Surveys

The major focus of these more recent large-scale national sex surveys has been on behavior (ACSF Investigators 1992; Johnson et al, 1992; Laumann et al, 1994; Spira et al 1993; Wellings et al, 1994), with most of the data on homosexuality based on responses to questions about sexual partners and practices. In the National Health and Social Life Survey (NHSLS), the most comprehensive probability-based survey of sexual behavior ever carried out in the United States (Laumann et al, 1994), questions pertaining to homosexuality were asked, covering three dimensions: behavior, desire and identity.

'Behavior' mainly refers to same-gender sexual experience or partners since the age of 18. 'Desire' was measured by combining responses to two items in the survey: sexual attraction to same-gender individuals and the appeal of having sex with someone of the same gender. Although homosexual 'identity' is a complex phenomenon, in the NHSLS study, it referred simply to a self-definition as homosexual or bisexual (or a variant of the same, such as gay or lesbian). Desire and identity were asked about in the present tense, although in a global way (p.56).

In the NHSLS, some persons reported one of the three dimensions of homosexuality but not the other two. For example, there were both men and women who reported sexual experience with persons of their own gender but no same-gender desire or identity. This could occur in many scenarios, including situational homosexuality in the absence of opposite gender partners as occurs in prisons and other single gender institutions. In addition, in the United States as in many cultures and groups, men who play the 'masculine' or 'active' role in sex with other men (i.e. the inserting partner in fellatio or anal intercourse) have not historically been considered homosexual and may not think of themselves as homosexual (Almaquer, 1991; Alonso & Koreck, 1989; Carrier, 1980; Chauncey, 1994). On the other hand, it was not surprising to find persons who were aware of sexual feelings toward

individuals of their own gender or who found the idea of having sex with someone of their own gender appealing but who have never actually had this experience and who do not consider themselves to be either homosexual or bisexual (Michaels, 1996).

> Identity is conceptually distinct from either desire or behavior. Conceivably, there are individuals who have either had homosexual sex or have experienced some degree of homosexual desire but who do not consider themselves either homosexual or bisexual. It is harder to comprehend persons who say that they are homosexual or bisexual but who do not experience homosexual desire, because a self-definition as homosexual or bisexual usually develops over time and depends at least on previous conscious desire. However, we may see an example of this in cases of strong identification with gay or lesbian culture or politics (e.g. the 'political' lesbian or 'woman-identified woman'). Homosexual culture and politics often seem to emphasize a general opposition to 'straightness' or 'normality' rather than specific sexual practices and desires; this might lead some to identify themselves as 'gay' or 'queer' independently of feelings or experience (p.44).

The 1992 National Health and Social Life Survey results, which categorize prevalence of homosexuality by identity, behavior, and desire are presented in the following chart:

	WOMEN		**MEN**
Only	0%	Identity Only	2%
Identity + Behavior	0%	Identity + Behavior	0%
Identity + Desire	1%	Identity + Desire	1%
Identity Identity + Desire + Behavior	15%	Identity + Desire + Behavior	24%
Behavior Only	13%	Behavior Only	22%
Behavior + Desire	13%	Behavior + Desire	6%
Desire Only	59%	Desire Only	44%

Figure 1. Interrelationship of same-gender sexual behavior, desire, and identity in women (left; n=150, N=1749) and men (right; n=143, N=1410), ages 18-59 years, in the United States who reported any adult same-gender sexuality. Results are based on data from the National Health and Social Life Survey in 1992 (Laumann et al., 1994). Behavior referred to same-gender sexual experience or partners since age 18 years. Desire and identity were asked about in the present. Desire was measured by combining responses to two items in the survey: sexual attraction to persons of one's own gender and appeal of having sex with a person of the same gender. Identity referred to self-definition as homosexual or bisexual (or a variant such as gay or lesbian).

Prevalence by Social and Demographic Group

Having found a medium for definition of exactly who a homosexual is and by what measure the appellation is determined other variables are encountered which affect statistics. Reported rates of homosexuality vary according to many social and demographic variables, including age, marital status, education, religion, race, and whether or not participants reside in urban areas (Michaels, 1996). The examination of features of sexuality in the context of social and demographic factors can be complex. The temporal order of influence may vary, as gender and race clearly predate sexual experiences. Variables such as education, religion, and urban migration may be at least partially the result of sexuality, and the observed difference may be the result of reciprocal or interactive processes (Michaels, 1996).

The results compiled so far do demonstrate a high degree of social organization of homosexuality, which appears to be unevenly distributed in American society. Similar patterns of variability in prevalence exist in other Western industrial countries such as England and France (Spira et al, 1993; Welling et al, 1994). The degree of social variability this indicates should alert one to the importance of the social environment and its influence on and the complex task of describing the prevalence of homosexuality (Michaels, 1996).

Stability of Sexual Orientation

Whether homosexuality and heterosexuality are objectively separate categories (as the NHSLS results indicate may be the case in men), or arbitrary divisions of a spectrum of sexual orientation (as seems to hold true for women in the same report) and as Le Vay maintains, there remains a question of the stability of sexual orientation over the life span. Instability of sexual orientation has been used persuasively to support the role of sexual reorientation interventions. Rust (1993) reports the results of a study of several hundred women, in which it appears that a significant number of women shift from a bisexual identity to a lesbian identity, with some fluctuating between the two. Rust also notes, however, that it is uncommon for a woman who has adopted a bisexual or lesbian identity to subsequently adopt a heterosexual identity.

A similar study of gay identified men, (Lever, 1994) indicated that many (about 40%) had identified as bisexual at a relatively early age (16 to 25 years). This was seen as a transitional phase towards the adoption of a homosexual identity. Le Vay concludes that sexual

orientation as measured by identity often changes, usually in the direction of heterosexual to bisexual to homosexual. Le Vay believes that this process of change is clearly related to the challenges of the coming out process for men. On the other hand, he believes that some women truly change their sexual orientation from heterosexual to homosexual (often late in life).

Summary

Although new studies reveal a lower prevalence than the 10% widely believed to be valid after the initial Kinsey reports, other aspects of the reports are still largely upheld (higher rates of homosexuality in men than in women and in adolescents than in adults) (Michaels, 1996). The seven point Kinsey scale (0-6) is still widely found in literature on sexual behavior.

Significant social stigma associated with non-heterosexuality remains and there is therefore a constant risk of under-reporting non-heterosexuality. Interviewing skill clearly impacts the quantity and quality of under reporting and may confound comparisons between studies and over time. Ethical discussions about sexual reorientation that focus on efficacy are plagued by similar problems. Ethical discussions that are built on a foundation of unstable research are inherently unstable.

Chapter 4: Cross Cultural Sexuality

The Western medical community is charged with the responsibility of caring for all society's members, not just the most vocal groups. The two groups most vocal in the ethical and bioethical discussion of sexual reorientation have been the middle-class conservative religious and the middle-class lesbigays. American and Western European societies are no longer culturally homogenous and have not been for centuries.

The emotional and intellectual significance of sexuality for any one individual is related to an integration of the influences of the 'culture of origin' and the 'dominant culture' that one finds oneself in at any given period in time. Any ethical or bioethical discussion must acknowledge cross-cultural sexualities and the redefining of normal between cultural sub-groups. Contrasting sexuality between cultures can also help to illuminate some of our frequently inappropriate assumptions about the interplay of biology and environment. Pertinent revelations from a review of cross-cultural sexuality also serve to root out assumptions held by academic and professional persons who carry their own inherent cultural biases.

Cross-cultural issues are unavoidable when so many intra-cultural conflicts exist. The normality of homosexuality and bisexuality in Western medicine has been under almost continuous debate since the American Psychiatric Association removed homosexuality from the *Diagnostic and Statistical Manual* (*DSM*). The study of homosexuality has often been driven by the effort to posit its ultimate causes. From Freud's late nineteenth century discussions of same-sex desire as an 'inversion', characteristic of 'psychic hermaphrodites' (Freud, 1962), to the large-scale survey studies of Kinsey et al (1948) in the mid twentieth century, the idea that same-sex practices were frequent but usually transitional became normalized. The cause of homosexuality remains an important source of inspiration for the present explosion of study in anthropology, social history, and studies of gay men and lesbians demonstrating the significance of same-sex roles, institutions, and subcultures (Herdt, 1983).

Herdt (1994) warns that we must be aware of the fundamental deconstruction of the construct of homosexuality as a Western, typically culture-bound concept, insofar as it implies a certain social role and identity deriving largely from the nineteenth century, and not present in many other cultures and historical periods. Efforts to understand the meanings of

same-sex behavior must therefore take account of local roles, knowledge, and practices (Herdt, 1988). Strong preconceptions about homosexuality include the perception that it is always deviant or perverse, that it is rare or absent from most societies, or that, if it occurs, same-sex behavior is stigmatized or punished (Herdt 1984, 1993; Mead 1961).

At the turn of the century, Freud (1962) challenged such views by suggesting that homosexual activity occurred in various archaic and tribal societies. He maintained that sexual behavior was more heterogeneous than was believed, even in Western society. Freud's famous phrase 'polymorphous perverse' was meant to indicate the potential of humans to manifest sexual acts with both genders, which behavior was subject to social regulation. Kinsey et al (1948) provided massive empirical evidence supporting this idea in their study of American society, demonstrating the prevalence of homosexual behavior, with 37% of all men in America having experienced significant homosexual contact at some point in their lives. The effect was to disengage sex from reproductive behavior and to indicate how homosexual-heterosexual dichotomies are more an idealized cultural model than an empirical fact (Herdt, 1988).

In cross-cultural studies, a similar point was made soon afterward in the classic study by Ford and Beach (1951), who found that homosexual behavior was socially acceptable and normative for certain people in 64% of the 76 societies studied. Carrier (1980) has gone further and divided cultures around the world into those that are approving, disapproving, or neutral with regard to homosexual acts, illustrating that societies differ greatly in their conceptions of homosexuality. The North American value system, which negatively stigmatizes same-sex eroticism, is very different than that of many societies (Herdt, 1988).

Conceptual Refinements

The struggle for a working definition of homosexuality has provoked elaborate speculation from academics. The theoretical separation of phylogenetically universal determinants from socio-culturally variable elements (e.g. masculinity and femininity) in human sexuality has been raised as possibly relevant when defining and describing non-heterosexuality (Money & Ehrhard, 1972; Stoller, 1980). Another apparently difficult concept, which if grasped could aid the understanding and meaning of homosexuality is the difference between sexual identity and sexual behavior (Herdt, 1988). That someone engages in a particular *gendered* sexual act

does not mean that he or she has the characteristics associated with the general category of homosexual, bisexual, or heterosexual (Herdt, 1989). Thus a woman may marry and have children but regard her sexual orientation as lesbian or a man may engage in sexual activity with males but regard himself as heterosexual (Money & Ehrhard, 1972; Plummer, 1975). We must, therefore, distinguish homosexuality as a state of being - an essence - rather than determined necessarily from same-sex acts and transient relationships, which may not involve homoerotic sex-object choice and intentionality in the same way (Stoller, 1980; Stoller & Herdt, 1985). Stakeholders and their critics in the debate around sexual reorientation are often poorly equipped to manage such refinements in the way sexuality is organized. Culture is shaped first and foremost by thought.

A recent survey reveals that these conceptual refinements could help us to cluster culturally determined same-sex patterns found historically and cross-culturally into four forms, giving the academics, at least, something to agree on: *Age-Structured Same-Sex Practice, Gender Transformed Same-Sex Practice, Role of Class-Specialized Same-Sex Practice and Gay and Lesbian-Egalitarian Same-Sex Practice* (Herdt, 1987).

Age-Structured Same-Sex Practice

Age-Structured Same-Sex Practice defines institutionalized same-sex acts between males of unequal ages. These acts are common but unevenly distributed throughout the world (Adam, 1986). They are customary practices, usually obligatory for older and younger males, which are associated with normative gender development (Herdt, 1988). Age-structured homoeroticism occurred in ancient China, Japan, Islam, and in certain Indo-European traditions, but the most famous example is known from our cultural ancestors, the ancient Greeks (Dover, 1978). Ritualized female homosexual contacts were also known among the Greeks (Herdt, 1988).

In the tribal worlds of contemporary non-Western people, age-structured homosexuality is known to exist in Africa, lowlands South America, the Pacific Islands, and elsewhere, but it has been most studied in New Guinea and the South Seas (Herdt, 1984). Here, as occurs among the Sambia of highland New Guinea, age-structured homoerotic activities are implemented through initiation rites, when Sambian boys aged 7-10 years are inducted into

ritual and military organizations. Sambian males experience many years of these practices, first as semen recipients and later, in adolescence, as semen donors. At fatherhood, the Sambia forbid additional boy-inseminating practices (Herdt, 1981). These males experience both passive (fellator) and active (fellated) homosexual roles in the course of their lives, yet they, like the Greeks, nonetheless marry and have children (Herdt, 1987). In some New Guinea societies, however, this homoerotic relation with younger males continues throughout life, even into old age (Van Baal, 1993). A survey of all South Seas societies has shown that this approved pattern of age-structured boy-inseminating occurs in between 10% and 20% of cultures and is probably an ancient practice, the result of migrations and adaptations over several thousands of years (Herdt, 1993).

Gender-Transformed Same-Sex Practice

A different form of homoerotic practice is based on the adoption and role of the opposite sex in a given society (Herdt, 1988). Sometimes it is referred to as 'institutionalized cross-dressing' or 'transvestitism'. Gender transformation often begins in childhood, has recognized customs associated with it, and is acknowledged and supported by society (Blackwood, 1986). The institution of the Berdache among the North American Indians is the best-known example, according to Herdt (1988). Some 115 Indian tribes recognized the Berdache, in which boys acted and dressed as girls and assumed the roles of girls, with some cases in which girls adopted the roles of boys (Herdt, 1988). Berdache could marry, adopt children, acquire property, and participate in most aspects of group life. They were not stigmatized and, in some societies, were revered for their special qualities and pragmatic socioeconomic contributions to the group (Devereux, 1937; Williams, 1986).

Role of Class-Specialized Same-Sex Practice

A third form of sexual contact occurs in those societies in which engaging in a same-sex act is based solely on the entitlements of a role or status not widely held (Herdt, 1988). One of these patterns is divine bisexuality, as described by Herdt. Those who became shamans among the Chukchi tribe of Siberia were entitled by supernatural authority to engage in

homosexual behavior, even though this was generally disapproved of for the wider society (Herdt, 1988).

A more recent case is that of the female factory workers of the nineteenth century Canton Delta in China. Young Chinese women who lived and worked in silk factories formed erotic and economic bonds with each other and usually did not marry, even though female homosexual contact was disapproved of by the patriarchal culture of China (Blackwood, 1986).

This example reveals how institutionalization, urbanization, and the development of a class system may be antecedents of the category 'homosexual' in the modern period (Herdt, 1983). Indeed, the identification of the role of the artist with homosexuality and the incipient gay culture of eighteenth and nineteenth century England suggest as much (McIntosh, 1968; Weeks, 1985).

Gay and Lesbian - Egalitarian Same-Sex Practices

From the late nineteenth century until the present, the emergence of sexual reform movements led to the creation of modern gay and lesbian communities in many parts of the United States (Herdt, 1988). According to Herdt, (1988) this movement represents a fusion of public and private, sexual and gender, and sexual and political and a fusion of role and sexual orientation and identity as previously defined. Foucault (1986) showed that social constructions of homosexuality in this sense did not emerge until the medicalization and stigmatization of gender-deviant behavior were disputed by social history. Coupling this sexual category with early homosexual rights movements in Germany, England, and the United States provided the basis for the advocacy of the human right to live a gay lifestyle on a permanent basis (Herdt, 1988). Thus, gayness has become a sexual orientation (a particular kind of homosexuality), a social identity, and a political movement (Herdt, 1993). Clearly, gayness is a new form of homosexual practice, which in its fullest sense is historically unique (Herdt, 1988).

The psychosocial conditions of being gay or lesbian in current society must, therefore, be understood in terms of cultural place and historical time (Herdt, 1988). Being gay or lesbian is a commentary on the tendency of Western societies to dichotomize body and mind,

masculinity and femininity, and homosexuality and heterosexuality (Herdt, 1988). The modern gay movement both reflects and mediates these dualities, indicating that social and erotic transformation is a part of human potential, as suggested by Freud (Herdt, 1988).

The coming out process of identity development can be seen in the light of this commentary (Herdt, 1988). Gay men and lesbians undergo a profound process of cognitive change within themselves, because the self is first placed in a heterosexual category, by virtue of growing up in a heterosexual environment, but is then placed into the homosexual or gay category that replaced it (Dank, 1971). The study of adolescents coming out further substantiates this trend (Herdt, 1989). The concomitants of the process are complex and multidimensional, but they obviously depend on cultural barriers to the expression of homosexuality in society (Hooker, 1965; Weeks, 1985). Western negativity toward homosexuality must be seen in the light of a historically determined stigma, the symbols of which, in religious and political discourse, are inextricably tied to broader socioeconomic issues that we are only beginning to understand (Herdt, 1988).

Impact of Cross-Cultural Issues

The cross-cultural material on human sexuality points to the fragmentary nature of our understanding of sexual development, especially outside Western society. New classifications of homosexuality help us to comprehend the variety of sexual identities in terms of context, meaning, and behavioral forms. They are useful heuristics, but they remain analogies and models that must inevitably give way to new findings in the future. Recent work on bisexuality provides a similar reminder of the tentativeness of explanatory principles regarding sexual development in our own cultural tradition (Herdt, 1983, p.55).

Cross-cultural studies of sexual development reveal the great contribution of social structure and cultural meaning to the expression of individual sexual desires and relationships. Biosocial antecedents and personality factors clearly play a role in this developmental process, but at present it is difficult to say how much, in what proportions they are combined and with what frequency they exert themselves in sexual development (Ehrhardt et al, 1982).

Policy makers in health care are obliged to acknowledge that cross-cultural issues are often overlooked, particularly when struggling to manage the competing interests of vocal political groups within the dominant culture of a given 'system'. The examination of reorientation

therapies and interventions as products of a cultural value system and history should reshape approaches to the resolution of related ethical and bioethical conflicts.

Chapter 5: Bisexuality

One of the reoccurring themes in the debate over sexual reorientation is the denial of the ability to change a true homosexual into a true heterosexual and insistence that any shifts resulting from interventions occur from the change of behavior or because the homosexual was actually an unidentified bisexual. There is denial of the existence of bisexuality with the insistent reformulation that it is only ever a transitional identity state. It is for this reason that any thorough discussion of sexual reorientation must explore bisexuality as both a transitional phenomenon and a persistent behavioral and identity state.

Against the backdrop of AIDS related sexuality research the last two decades have produced a greater acknowledgment of bisexuality as a valid sexual orientation and identity. This is a result of the changes in how the term 'bisexuality' has been defined in theory, clinical practice, and research (Fox, 1996). Fox identifies two primary factors that have contributed to a more affirmative approach to bisexuality: 1) the elimination of homosexuality as pathology plus development of lesbigay identity theory and 2) the replacement of the dichotomous model of sexual orientation with a multidimensional model of sexual orientation.

Fluidity

It is no accident that theories of bisexuality have progressed along side theories of homosexual evolution. The histories of bisexuality and homosexuality are inextricably linked (Money, 1987, 1988) and discussion of one demands consideration of the other.

DeCecco and Shively (1983) have reconfigured the study of bisexuality in its historical and cultural contexts and have written an essay that elucidates this view. Their approach combines the historiography of Foucault (1986) with a re-analysis of the ideas of Freud, Kinsey, and others. In reviewing their ideas, it is wise to consider same-sex practices in the context of human sexuality in general (Herdt 1981, 1993). DeCecco and Shively (p.12) wonder at the "... willingness of historians to make a biological concept the foundation of a historical inquiry that has consisted of describing the circumstances under which this identity existed in the past." They see the focus on isolated individuals and the biological motivation of essences as imports by the social sciences from medicine and the natural sciences (DeCecco & Shively, 1983). According to them: "The structure of sexual relationships ...

exists as an intersection of both the uniquely personal meanings of the individual partners and a locus in history and society" (p.13). The impact of history and society on sexual formulations is essential to policy development on sexual reorientation interventions that will span decades and impact a variety of diverse subcultures.

As innovative as the ideas are, these essays do not confront the whole system of " ... spirit, body, mind, personality, or social relations" that DeCecco and Shively (p.14) describe as ingredients of the concept of sexual identity. DeCecco and Shively, Hoffman (1983), Paul (1983), Herdt and Boxer (1993) most approximate this goal in other essays. Working against the goal of greater enlightenment, the absence of a holistic perspective toward development fosters culture-bound conceptualizations and limits an understanding of the impact that a new identity - being gay - has on North American culture and on Western consciousness (Altman, 1982; Greenberg & Bystryn, 1984).

Kaliedescopic in its manifestations in human behavior, homosexuality in the Melanesian culture presents yet another colorful turn. Ritual is the focus of the complex symbolism of Melanesian homosexuality. Homosexual contacts are begun in elaborate adolescent initiation rites among young males. Taboos and strict codes of conduct govern homosexual contacts (e.g. incest taboos comparable to those dictating heterosexual contact are evident) and these practices are supported by the society as a whole or by the men's religious organizations. Ritual is, therefore, inextricably entwined with homosexual behavior and sexual identity among the Melanesian (Bateson, 1936; Herdt, 1982).

Whitehead (1981) has posited that Melanesian ritual originates from a collective response to inherent biosocial elements of the human condition. The Melanesian data are directly relevant to the *essentialist* explanation of homosexual and bisexual identity (Herdt, 1988). In his review of the extant data from the 1860s to the present, Herdt (1993) has shown the occurrence of the ritual practice of homosexual activity in about 40 different societies.

Throughout the DeCecco and Shively collection of essays the term 'fluidity' appears as a metaphor for bisexuality. Fluidity implies the rigidity of the old heterosexual-homosexual dichotomy, which is perceptively analyzed by Murphy (1983). The term 'fluidity' denotes that capability of flowing or the capacity to be easily changed and not fixed or solid (Herdt, 1983). This leads Herdt to raise the question (p.14): " ... what is it in the bisexual identity that is changeable: sexual orientation, gender role, gender-identity, object choice, erotic

technique used in sexual contact (e.g. oral and anal intercourse), exclusivity of sexual contact, or the degree of intimacy characterizing a contact or the relationship?" He asserts that the existence of fluidity as a metaphor in sexology raises new questions about the prominence of bisexuality in scientific and popular culture.

To bolster this conjecture, Herdt identifies three interrelated aspects of sexual development and fluidity:

- Culturally constituted life-cycle transitions that allow relative flexibility of bisexual choices.
- Cultural systems of sexual signs and symbols used as contrasting features in the stimulation of bisexual erotic response.
- Bisexual fluidity as a paradigm of eroticism that suggests a broader field of arousal than is normative in Western societies (Mead, 1961).

The correlation between social and sexual interactions in the individual's social network. Herdt has contributed new ideas to theoretical evaluation of bisexuality.

Typologies

To discuss bisexuality further in the context of sexual reorientation, it is important to grasp the lexicon of the bisexual landscape. Klein (1978) differentiated *transition, historical, sequential,* and *concurrent* bisexuality. For some individuals, bisexuality does not represent a stage in the process of coming out as lesbian or gay (*transitional* bisexuality), whereas for others a gay or lesbian identity *is* a step in the process of coming out as bisexual (Byne, 1996). *Historical* bisexuality refers to individuals whose sexual lives are, at present, either heterosexual or homosexual, but who have experienced both same and opposite gender sexual attraction or behavior in the past. *Sequential* bisexuality refers to individuals who have had relationships with both genders, but only with one person during a given period, while *concurrent* bisexuality refers to those who maintain relationships with both genders simultaneously. *Defensive* bisexuality is the term used by Ross (1930) to describe a person hiding or exploring a homosexual orientation. *Married* bisexuality refers to homosexual behavior that takes place away from the family environment and *ritual* bisexuality describes the homosexual behavior prescribed for all members of a society as in the Melanesian circumstances discussed above. *Latin* bisexuality describes the cultural phenomenon in Latin cultures where the partner that is the 'inserter' is considered heterosexual, while the

'recipient' is deemed homosexual. *Experimental* bisexuality describes circumstantial homosexual behavior, *secondary* bisexuality refers to situations when no heterosexual outlets are available (prison), and *technical* bisexuality is often an element of prostitution.

Philosophy of Bisexual Identity

Bisexual identity theory, in all its complexities, is as important as gay and lesbian identity theory if we seek to grasp reaction to the sexual reorientation phenomenon. It is insufficient to view bisexuality through a monocular lens of incomplete homosexual identity development or incomplete heterosexual identity development. When the illness model of homosexuality was repealed in 1973 by the American Psychiatric Association (Bayer, 1981) development of affirmative models of lesbian and gay identity began formation (Cass, 1979, 1983; Coleman, 1981; Troiden, 1988). Many, like Cass, view bisexuality self-identification negatively and describe it as the prime example of identity foreclosure, delaying or preventing the formation of a positive homosexual identity. Coleman, in contrast, applied stages of identity formation similar to those identified in gays and lesbians to bisexuals. Troiden, like Coleman, viewed bisexuality as a valid orientation and identity.

The dichotomous model of sexual orientation perpetuates the belief that bisexuals are psychologically maladjusted (Byne, 1996), but a large number of studies have found no evidence of psychopathology or psychological maladjustment in bisexual men and women (Fox, 1996). Weinberg et al (1994) saw bisexuality as an add-on identity to an already established heterosexual identity, while homosexual identity development is seen by Cass (1979) and others as a replacement for heterosexual identity.

Bisexual identity development has not been conceptualized as a linear process with a fixed outcome, as in theories of heterosexual, lesbian, and gay identity development, but rather as a complex and open-ended process (Fox, 1996). For some individuals, bisexual identity remains constant, whereas for others bisexual identity varies in response to changes in sexual and emotional attraction, behavior, and relationships, as well as social and political environmental contexts (Carroll, 1996). Perhaps because of these divergent theoretical views, the impact of sexual reorientation interventions on the process of bisexual identity development is poorly understood.

Philosophy of Bisexual Orientation

In the twentieth and early twenty-first centuries, bisexuality has been the overlooked middle child in the analysis of marginalized sexualities. The early twentieth century theorists continue to directly impact the ways bisexuality is framed by academics, professionals, and members of the public. These theorists, many of whom were contemporaries of Darwin, used the concept of bisexuality to explain homosexuality in terms of evolution theory (Ellis 1922; Freud, 1962; Kraft-Ebing, 1886; Weinberg, 1908). Freud, heavily influenced by evolution theory as were other early biopsychosocial scientists, used the theory of bisexuality to account for homosexuality, which he saw as indicative of arrested psychosexual development. At the same time, he believed that *all* individuals have some homosexual feelings: "The most important of these perversions, homosexuality ... can be traced back to the constitutional bisexuality of all human beings ... Psychoanalysis enables us to point to some trace or other of a homosexual object-choice in everyone" (Freud, 1962, p.45).

Regarding bisexuality, Kinsey et al (1948) departed from traditional thinking about sexual orientation and emphasized the inadequacy of a dichotomous model:

> Males do not represent two discrete populations, heterosexual and homosexual. The world is not divided into sheep and goats. Not all things are black and white. It is a fundamental of taxonomy that nature rarely deals with discrete categories. Only the human mind invents categories and tries to force facts into separate pigeonholes. The living world is a continuum in each and every one of its aspects. The sooner we learn this concerning human sexual behavior the sooner we shall reach a sound understanding of the realities of sex (p.219).

Other authors, such as Shively, DeCecco, and Storms (1980) viewed heterosexuality and homosexuality as independent aspects of sexual orientation and not as bridgeable via bisexuality. There has been a variety of grids, scales, and scores to quantify and differentiate the features of sexual orientation along multidimensional lines over the years, all with rather time-limited popularity.

Complicating further is the fact that compared to heterosexuality and homosexuality, very little scientific study has been conducted specifically on bisexuality. Yet observing bisexuality in detail is Schoen (2002):

> Based on the studies that have been done, it appears that bisexuals are not people whose orientation is fundamentally homosexual but who have some heterosexual contact on the side. Nor are they people whose orientation is

fundamentally heterosexual but who enjoy homosexual contact on the side. Also, fundamentally, they are not people who, at one point in their lives, engage in sexual behavior with persons of one sex and then at another point, engage in sexual behavior with persons of the other sex, although this pattern is sometimes called transitional bisexuality. Rather, bisexuals are people who are sexually attracted to persons of both sexes during the same general time period in their lives.

It is thought that people develop and experience bisexuality in a number of different ways. For some it begins as a form of experimentation that adds a spark to their sex lives, but it does not become the main arena of sexual activity. For others it is a deliberate choice to participate in whatever feels best at the moment. Three particular sets of circumstances have been thought to be conducive to bisexuality: (a) Sexual experimentation in a relationship with a close friend is quite common among women and can also occur between two male friends or a male homosexual may develop a sexual relationship from a previously casual or friendly relationship with a woman. (b) Group sex is another avenue for bisexual experimentation. (c) Finally, some people adopt a bisexual philosophy as an outgrowth of a personal belief system. For instance, some women who have been active in the women's movement find they are drawn closer to other women by the experience and translate this closeness into sexual expression.

Men who are bisexual are likely to experience homosexual attraction and engage in homosexual experiences before they become aware of their bisexuality. For women, on the other hand, the trend is to experience heterosexuality first.

Researchers who have studied female bisexuality note that some women who identify themselves as bisexual say that they have some emotional needs that are best met by men and others that are best met by women. Some bisexual men offered this explanation too, but much more often the male bisexual explains his sexual lifestyle in terms of a need for variety and creativity.

People usually discover their bisexual orientation later in life than either homosexuals or heterosexuals. The majority of people model the heterosexual lifestyle and drift into bisexual relationships without consciously thinking about it initially. Most individuals who discover their attraction to the same sex try to deny their interest and attempt to fit in with the more socially acceptable heterosexual lifestyle for a while. Usually by adolescence there is increasing internal conflict about their sexual preference that may not be fully resolved until adulthood.

Because it is commonly thought that people are either heterosexual or homosexual, even by people with bisexual interests, these people seem to struggle for a longer period of time trying to conform to one lifestyle or the other. It is common for people to be well into their 20s or 30s before accepting their bisexual orientation. Society's definitions of what is normal, appropriate, right and natural have an enormous influence on how bisexual people feel about their sexual orientation. Given the negative bias towards bisexuality, it is not unusual for women and men with a bisexual orientation to feel alienated from and oppressed by both the heterosexual and homosexual communities. For them, this can raise serious questions about their sexual identity. Bisexual people have problems

> similar to those that homosexual people have in "coming out" and making their orientation known to family and friends (pp.2-9).

With Schoen's more detailed examination of the models of sexuality and from viewing sexual orientation from both historical and contemporary perspectives, the distortions and misconceptions surrounding sexual reorientation become easier to identify in the debate. As evidenced above bisexuality must be viewed as both a transitional phenomenon and a static sexuality and sexual identity. Still, a coherent bisexual philosophy continues to remain elusive.

Chapter 6: Heterosexism, Homonegativity, and Homophobia

> *I believe that one day the world will judge the witch hunt against homosexuals ... as an unbelievable injustice perpetuated by supposedly 'moral' people against innocent groups, just as harshly as it judges the Spanish Inquisition and the Holocaust. Both the Church and the Nazis believed they were acting in good faith* (McLean, 1998).

Heterosexism, homonegativity, and homophobia should be considered in this discussion since they are key emotional and cognitive states that can drive the desire for heterosexuals to promote sexual reorientation interventions. Potentially these viewpoints can also motivate desire for non-heterosexuals to request sexual reorientation intervention. No ethical exploration of the issues surrounding sexual reorientation can avoid acknowledgment of the impact of sexual bigotry, guilt, and shame on pursuit of these interventions.

Herek (1990) defines 'heterosexism' as the ideological system that denies, denigrates, and stigmatizes any non-heterosexual forms of behavior, identity, relationship, or community. Weinberg coined the term 'homophobia' to characterize heterosexuals' dread of being in close quarters with homosexuals as well as homosexuals' self-loathing. Homophobia has since been used to describe:

- Hatred of homosexuality.
- Hatred of homosexuals.
- Fear of gays and lesbians.
- A desire or attempt to discriminate against homosexuals.

Within the general population, the dominant meaning places 'homophobia' in the same class as 'racism', where hatred, fear, and discrimination are directed against persons of different races, and 'sexism' where victims are of a specific gender (Carroll, 1996).

Herek (1996) suggests that 'homophobia' should only be used to describe the negative attitudes of homosexuals towards their own homosexuality. Shields and Harriman (1984) argue against the use of the term 'homophobia', positing that anti-gay attitudes rarely, if ever, meet the criteria for a true 'phobia'. Herek argues against popular use of the term because it implies an individual or clinical entity instead of a social phenomenon that he claims is rooted in cultural ideologies and inter-group relations.

'Homonegativity' has been offered up as an alternative to 'homophobia'.

Heterosexism

In greater detail, Herek, states that heterosexism refers to prejudice comparable to racism, antisemitism, and sexism. He notes the term is often used pejoratively in the literature of homosexuality.

Cultural heterosexism refers to those prejudices manifest in societal institutions and customs, whereas psychological heterosexism refers to individual prejudice (Herek, 1996). Herek (1994) and Wood (1990) note that most Americans are inculcated with consistent condemnation of homosexuality and homosexual behavior as being morally wrong sin, to regard it as unnatural, and that the proper reaction is to express disgust toward it.

This cultural imprinting is not without dire consequence. In a review of 24 separate questionnaire studies with samples of gay men and lesbians, Berrill (1992) reported that a median of 44% had been threatened with violence because of their sexual orientation, 33% had been chased or followed, 25% had had objects thrown at them, 13% had been spat on, and 80% had been verbally harassed. It appears clear, then, that homosexuals are predictably and routinely victimized in Western society. Herek (1996) notes that, although Americans have demonstrated an increasing willingness to extend basic civil liberties to gay men and lesbians, most heterosexual Americans continue to condemn homosexuality on moral grounds and to reject or feel uncomfortable about gay people personally.

There are discernable patterns in the etiology of this hate crime behavior, Herek (1984, 1991) and Kite (1994) note that, in contrast to heterosexuals with favorable attitudes toward gay people, those with negative attitudes are:

1) Less likely to have had personal contact with gay men or lesbians.
2) More likely to be strongly religious and to subscribe to a conservative religious ideology.
3) More likely to support traditional gender roles.
4) More likely to believe that sexual orientation is a matter of personal choice.
5) More likely to be older and less well educated.
6) More likely to have resided in geographic areas (e.g. rural mid-western or southern United States) where negative attitudes represent the norm.

Herek (1994, 1993), Capitanio (Herek & Capitanio, 1995), and Glunt (Herek & Glunt, 1993) report that heterosexual males tend to manifest higher levels of prejudice than heterosexual females, especially toward gay men. One explanation for the sex difference is, in part, that heterosexual females have greater likelihood of personal contact with openly gay

people, which circumstance correlates strongly with greater acceptance of lesbians and gay men (Herek, 1994).

Such opportunities for contact may be a product of the strong link in American culture between masculinity and heterosexuality which according to Herek:

> ... creates considerable social and psychological pressure for males to affirm their masculinity through rejection of that which is not culturally defined as masculine (male homosexuality) and that which is perceived as negating the importance of males (lesbianism). Because heterosexual women are less likely to perceive rejection of homosexuality as integral to their gender-identity, they may experience fewer pressures to be prejudiced and, consequently, have more opportunities for personal contact with gay people (1996, p.101).

In his extensive research Herek (1992) identifies four principal psychological functions that underlie heterosexual anti-gay attitudes. They are: experiential, value-expressive, social-expressive, and ego-defensive. His position reveals:

> ... any given manifestation of psychological heterosexism can serve one or more of these functions only when the individual's psychological needs converge with the culture's ideology. Anti-gay prejudice can be value-expressive only when an individual's concept of self is closely tied to values that have also become socially defined as antithetical to homosexuality. It can be socially expressive only insofar as an individual strongly needs to be accepted by members of a social group that rejects gay people or homosexuality, and it can be ego-defensive only when lesbians and gay men are culturally defined in a way that links them to an individual's psychological conflict (p.64).

Devlin and Cowan (1985) ironically observe that:

> One consequence of heterosexism is its effect on heterosexuals. Because of the stigma attached to homosexuality, many heterosexuals monitor and restrict their own behavior to avoid being labeled as gay. This pattern appears to be especially strong among American males. For example, many men avoid clothing, hobbies, and mannerisms that might be labeled 'effeminate'. Anti-gay prejudice also interferes with same-sex friendships. Males with strongly anti-gay attitudes appear to have fewer intimate non-sexual friendships with other men than do males with tolerant attitudes (p.468).

Herek, looking deeply, reports with persuasion:

> When expressions of heterosexism and homophobia function to reinforce a person's self-concept as a good Christian, appeals to other important values such as compassion and love of a neighbor, notions of patriotism, and the support for civil rights are more likely to change attitudes than factual refutations of incorrect stereotypes about homosexual individuals (p.480).

Prejudice against sexuality began with Eve and her apple. Its greatest enduring manifestation may be intractable social and religious opposition to lesbigay and other marginalized sexualities.

Biology of Homophobia

If arcane Biblical allegory cannot be solely blamed for it, can biology excuse homophobia? A study that was completed at the University of Georgia suggests a major cause of homophobia (Adams et al, 1996).

The study involved 64 white men, of which none had ever engaged in homosexual acts. Their sexual fantasies involved only women. 35 of them were rated as homophobic and 29 were rated as non-homophobic. For the purpose of the study, 'homophobia' was defined as a negative emotional reaction (fear, anxiety, anger, discomfort) to homosexuality. It was measured by a questionnaire called the *Index of Homophobia.* Each was shown three types of X-rated videotapes: heterosexual, lesbian, and gay. A plethysmograph device was used to measure the circumference of their penis as a gauge of sexual arousal. The two groups exhibited similar arousal when they viewed four-minute samples taken from one heterosexual and one lesbian movie. However, their responses to the male homosexual clip may have been surprising:

Figure 2.

Degree of Tumescence (Arousal)	Insignificant	Moderate	Definite
Homophobic men	20%	26%	54%
Non-Homophobic men	66%	10%	24%

The researchers concluded that the data were consistent with the belief that homophobic men have repressed homosexual desires. A less probable explanation is that the homophobic

men's erections were caused by anxiety during the experiment (Adams et al, 1996). If there is a biological component to homophobia, should we not ask if there is a biological intervention for homophobia? If there were a biological intervention for homophobia could the lesbigay taskforce justify supporting or opposing it?

Rationalization of Homophobia

It is important to understand the inculcated rationale for homophobia since it is not dissimilar to the rationale used in support of sexual reorientation interventions. Common arguments to support homophobic beliefs include:

- Homosexuality is unnatural.
- Homosexuality is an attack on the family.
- The Bible condemns homosexuality.
- Homosexuals recruit young people.

Many homophobics express the fear that people who remain anti-gay will begin to be considered bigots by the general population if gays and lesbians become a protected group of people as other minorities have done. In the words of one conservative Christian physician colleague (Rogers, 2001): "I don't want the federal government to marginalize me or the millions of others who share my beliefs." What irony.

It may be that some homophobia is tied to *the need to hate.* There is a phenomenon described by which people with low self-esteem appear to need to identify some minority that they can hate and feel superior to (Herek, 1996). Over the past 50 years, Jews, Afro-Americans, Communists, and most recently gays and lesbians have filled the role of hate-object.

Internalized Homophobia

The theme of internalized homophobia is a reappearing concept in academic, political, and clinical discussion of non-heterosexual desire for sexual reorientation. Herek (1996) has found that most children internalize society's ideology of sex and gender at an early age and that as a result, lesbians and gay men usually experience some degree of negative feeling toward themselves when they first recognize their homosexuality in adolescence or adulthood.

This internalized homophobia often makes the process of identity formation more difficult (Malyon, 1982).

'Coming out of the closet' or 'coming out', for short, is an idiom of gay and lesbian culture that refers to the recognition of a homosexual orientation within oneself, development of an identity based upon it, and its disclosure to others. Conversely, being 'in the closet' or 'closeted', for short, refers to passing oneself off to others as heterosexual despite personal identity to the contrary. Given the overt and covert risk of victimization and discrimination for homosexuals in Western societies, 'the closet' offers many advantages. Coming out is not a once-off challenge; it is an ongoing process that is repeated with each new societal situation and each encounter with a new person (Weeks, 1977).

According to Herek (1996), most lesbians and gay men successfully overcome the threats to psychological well being posed by heterosexism and reclaim disowned or devalued parts of themselves in the course of coming out, developing an identity into which their sexuality is well integrated. Conversely, people with a homosexual orientation who have not yet come out, and wish that they could become heterosexual, or who are isolated from the gay community, may experience greater psychological distress (Bell & Weinberg, 1978; Hammersmith & Weinberg, 1973; Malyon, 1982; Weinberg & Williams, 1974).

Respondents to the San Francisco Examiner's 1989 national survey of lesbians and gay men waited for an average of 4.6 years after knowing they were gay before coming out (San Francisco Examiner, 1989). Depending on the area of the country, between 23% and 40% had not told their families that they were gay, and between 37% and 59% had not disclosed their sexual orientation to coworkers (San Francisco Examiner, 1989).

Garnet et al, (1990) note that lesbian and gay victims of hate crimes may suffer a reemergence of internalized homophobia as they experience their homosexuality as a source of pain, danger, and punishment. Berrill (1992) identifies secondary victimization, consisting of increased discrimination and stigmatization, which may be experienced by hate crime survivors when others learn of the attack (being outed).

Internalized homophobia is clearly linked to the coming out process and reflects a confluence of individual, familial, and cultural heterosexist factors (Cass, 1983). Because of the complexities involved, many clinicians will refer patients with this problem to colleagues

who 'specialize' in the treatment of homosexual and bisexual patients struggling with identity formulation.

Social Costs of Homophobia

The Standing Commission of Human Affairs of the Episcopal Church wrote in 1994:

> Not only, must lesbian and gay youth withstand ridicule and, often, violence from their peers, they risk outright rejection from their parents should they decide to 'come out'. The combination of the culture's condemnation of homosexuality and the alienation from one's home and parents (supposedly a haven of security and support) causes unusually high rates of attempted suicide (p.2).

Substantiating this, a U.S. Health and Human Services (1993) report provides the following data:

> Gay adolescents are two to three times more likely than peers to attempt suicide, accounting for as many as 30% of completed youth suicides each year ... 26% of gay youths are forced to leave home because of conflicts with their families over their sexual identities. Up to half engage in prostitution to support themselves, greatly increasing their risk for HIV infection (p.13).

Further verifying the potential lethality of the painful process of coming out a University of Calgary study reports that gay men are much more likely to attempt suicide than other members of society (Wright, 1999). In 1988, the Los Angeles County Task Force on Runaway and Homeless Youth issued the *Report and Recommendations of the Task Force* that estimated that 25 to 35% of Los Angeles County street youth are gay, lesbian, or bisexual. Also in 1988, the Seattle Commission on Children and Youth of Seattle issued their *Report on Gay and Lesbian Youth in Seattle* that estimated that 40% of Seattle street youth are gay, lesbian, or bisexual. These figures are consistent with those of the National Youth Advocacy Coalition (NYAC, 1988).

It is clear that homophobia, homonegativity, and heterosexism are endemic in Western societies and that the societal implications for both heterosexuals and non-heterosexuals are powerful and far-reaching. A discussion of the bioethics and medical ethics surrounding sexual reorientation will necessarily involve an acknowledgment of the impact of these social phenomena and an appropriately posited response. The wise clinician armed with these facts must be aware of lurking or evident heterosexism or homonegativity in him or herself. Monitoring the impact this honestly unearthed autognostic information may have on clinical

effectiveness is imperative to relationships with patients. Awareness of homonegativity and heterosexism is no less important than knowledge of and respect for individual cultural diversity.

Section III: Original Theories and Theories of Origins

The clinical approach taken by sexual reorientation intervention is often attributed to supposed hypotheses regarding the biological or environmental origins of the specific individual's sexual orientation. Yet, the why and how of sexual orientation are irrelevant to other theories of intervention and some interventions persist despite the fact of the obsolescence of the original hypothetical formulation which has either been refuted or abandoned by the larger medical community. Debate surrounding sexual reorientation has focused not only on hypothetical origins of orientation associated with various interventions, but also on the nature of the interventions themselves, their social implications, and clinical outcomes.

Stakeholders on either side of the debate draw support from their view of the origins of sexual orientation.

Chapter 7: The Essentialists and Social Constructionists

At the core of debate about the origin of sexual orientation is the ongoing discourse between the essentialists and the social constructionists. These opposing camps speak throughout the literature and must be acknowledged. While Kinsey et al (1948, 1953) concluded that the division of individuals into simple dichotomous categories based on sexual characteristics was impossible and argued instead for an appreciation of diversity and variation in human sexuality, essentialists and constructionists take philosophically antagonistic approaches to postulating the origins of sexual orientation, identity, and behavior. These philosophically diverse perspectives fire cannon in the debate over the appropriateness and utility of sexual reorientation interventions.

Social Constructionism

In his study of human sexuality, McIntosh (1968) first described social constructionism and defined the distinction between homosexual behavior and the homosexual role. Plummer's (1975) discussion of sexual stigma is another important early contribution to the literature of social constructionism. Stein (1984) describes social constructionism as a belief in both the primary importance of social forces in shaping human behavior and experience and the fact that knowledge is not a reflection of the world but a product of discourse. LeVay describes 'social constructionism' as a school of thought in which concepts like 'representation', 'signification', 'discourse', and 'power' are more important than the details of individual development.

Gergen and Davis (1985) describe four assumptions that underlie social constructionist theory:

- Existing categories and ideas arise from language and context and do not serve as a map of the world. For example, commonly accepted concepts such as gender, emotion, and psychological disorder should not be taken as objective facts derived from observation but as social conventions.
- Common ideas and categories are artifacts of particular societies at specific periods and change with the passage of time. Even the most fundamental conceptions, such as ideas of self, identity, romantic love, emotion, reason and language, should be understood as being culturally and historically specific social constructions.
- The degree to which an idea gains prominence or survives over time should not be understood as a reflection of its empirical accuracy but rather as a function of processes of social interaction. According to this view, even methods for attaining truth and

knowledge, as represented in scientific rules, for example, can serve primarily as a means for achieving social control rather than for acquiring knowledge.

- Forms of descriptions and explanations serve as expressions of social meaning and action. Gergen and Davis cite the example of how conceptions about emotion, regarding the extent to which individuals experience choice or the lack of it significantly affect the implications for treating people suffering from certain emotional states like depression, anxiety and fear (pp.26-27).

The seminal work of the French philosopher Foucault, beginning with the publication of *The History of Sexuality, volume I, An Introduction* (1978), significantly shaped the parameters of the social constructionist debate about sexuality. Foucault argues that there is no inner human sexual drive, but that human potential for thinking and acting is shaped by social forces of regulation and categorization into various forms of sexuality at different times in history. According to this view, sexuality is not simply influenced or molded but is actually *created* by cultural forces (Stein, 1984).

Halperin's essay *One Hundred Years of Homosexuality* (1990), introduces the notion that homosexuality was brought into existence by the invention, in the late nineteenth century, of the word used to define it. By contrast, the philosopher Richard Mohr (1992) has argued persuasively that, even without the word, people could and did formulate the concept in earlier times. The idea that a thing doesn't exist until it is named is absurd. Gravity existed long before it was given the name *gravity*. Likewise, humans were capitalizing on the benefits and suffering the consequences of gravity long before it was named.

Weeks (1977), Katz (1983), and D'Emilio (1986) have documented the emergence of modern gay and lesbian identities and communities in specific historic periods. Altman (1982) and Epstein (1987) have explored the political aspects of the construction of contemporary homosexual identities. Janet Halley (1994), legal scholar at Stanford University, writes in her essay *The Construction of Heterosexuality* that:

> The ... class of heterosexuals is a default class, home to those who have not fallen out of it. It openly expels but cowardly incorporates the homosexual other, an undertaking that renders it profoundly heterogeneous, unstable, and provisional (p. 12).

Several collections of articles (Altman et al, 1989; Hart & Richardson, 1981; Stein, 1992) provide an examination of social constructionist approaches to homosexuality through the lens of psychology, sexology, and the social sciences. Additional writings in anthropology

(Herdt 1981, 1992), sociology (Greenberg, 1988; Ponse, 1978), history, (Halperin, 1990), and the humanities (Butler, 1990) have further elaborated the social constructionist analysis of sexual identity and homosexuality.

Social constructionism has of course been criticized, sometimes in ways that are mistaken. Vance (1989) outlines three criticisms of social constructionism:

> The first is the notion that social constructionism implies a devaluation of sexual identities. This equates the questioning in social constructionist writing of the cultural meaning of identity with an undermining or destruction of these identities (p.13).

Vance argues that this criticism trivializes social constructionist thinking. He identifies another criticism of social constructionism as deriving from the belief that it implies - as a result of its emphasis on the cultural construction of identity - that individual sexual identity is completely malleable, comparable to a set of clothing that can be tried on and disposed of at will. He further states that social constructionism does question traditional assumptions about the rigidity of identity and inability to change, implying that identity may not be as fixed and as immutable as we have been led to believe. The third criticism of social constructionism identified by Vance is that it assumes discontinuity and rupture in behavior and in the subjective experience of meaning across cultures and throughout history.

Essentialism

Essentialists maintain that fundamental differences exist between persons on the basis of their sexuality. These differences may derive from biological factors such as neuroendocrine, anatomical, or genetic features, from early developmental experience or from unspecified causes. Essentialism suggests the presence of a fixed sexual quality in a person, a lack of choice about it, and an underlying and enduring core basis for categorical descriptions of persons based on this quality (Stein, 1984). Stein writes:

> The description of essentialism has largely been developed in the writing of the social constructionists and refers to the view that sexual categories and sexual identities represent fixed personal characteristics that are inherent, objective, trans-cultural, and trans-historical. Essentialism treats sexuality as a biological force underlying genuine gender differences that in turn serve as the basis for sexual categories and identities. In relation to sexual orientation, essentialism argues that differences in sexual desire create categories of persons known as

> homosexual and heterosexual which are fundamentally the same across time and in different cultures (p.44).

Essentialist authors include Boswell (1980), Rich (1983), and Dynes et al (1990), although they don't identify themselves as such. Vance compares the absence of self-identified essentialists to the lack of awareness of heterosexual identity. Epstein (1987) argues that the distinction between essentialism and social constructionism reflects the earlier debate between nature and nurture as the cause of homosexuality. He describes the essentialist position as seeing sexuality as a "biological force seeking expression in ways that are preordained" and the constructionists as " ... treating sexuality as a blank slate, capable of bearing whatever meanings are generated by the society in question" (p.13). Epstein further characterizes essentialism as being consistent with a politics of identity practiced in gay and lesbian communities that demands the recognition of gayness as comparable to being a member of other groups defined by a difference such as race or ethnicity. In contrast, Epstein portrays social constructionism as an intellectual theory that may be seen as being out of step with gay and lesbian experience and the practice of minority politics (Stein, 1984). Stein also notes that:

> Although social constructionism is currently ascendant in academic circles, it is viewed by some, who see it as characterizing a social construction of sexuality with a voluntary choice about sexual orientation, as politically incorrect. This position is seen as strengthening the socially conservative argument that, if one can choose to be gay or lesbian, then one can be held responsible for one's sexual orientation and efforts can be undertaken to force individuals to choose to be heterosexual. Conversely, it is argued that essentialism represents a belief in the fixed nature of sexual orientation, for which a person cannot be held responsible (pp.83-84).

Troiden focuses on several additional concepts to draw a contrast between essentialism and social constructionism. He describes an essentialist emphasis on people's underlying sexual preferences and feelings to define sexual orientation, rather than on their behavior (Troiden, 1988). Richardson (1983) describes essentialist beliefs about homosexuality as:

> ... developing in three distinct patterns conceptualizing homosexuality as: 1) a state of being, associated with the creation of the concept of the homosexual person, 2) a state of sexuality; linking both sexual desire and behavior with the homosexual category and 3) a state of personal identity, involving the incorporation of the effects of both labeling and political forces into the notion of homosexuality (p. 32).

Troiden discusses the interest of essentialists in determining the causes of homosexuality arising from psychodynamic, hormonal, or prenatal factors, and in predicting adult sexual orientation on the basis of childhood characteristics and behaviors, particularly early gender role nonconformity. He classifies as essentialists adherents of the view that homosexuality is pathological (Bieber et al, 1962; Socarides, 1978) as well as those who believe that it is a normal variant (Bell et al, 1981; Green, 1987; Harry, 1982; Whitman & Mathy, 1986).

Essentialism, Social Constructionism and Medicine

Fiercely, Tiefer (1992) states that: "The major obstacle to a social constructionist approach to sexuality is the domination of theory and research by the biomedical model" (p. 311). Stein promotes another explanation, suggesting that

> ... the lack of attention to social constructionist theory within the field of mental health may lie in the deliberate movement away from viewing homosexuality as being a sexual orientation that is freely chosen. The idea that an individual's sexual orientation might change has been associated with the notion that one should attempt to change it in the case of homosexuals, an obviously disagreeable thought for those interested in promoting a higher degree of openness about and tolerance of homosexuality (p.87).

Stein highlights the essentialist belief now pervasive within the fields of psychiatry and psychotherapy, that sexual orientation is the expression of an inherent and largely fixed personal quality. This position has been used to argue against sexual reorientation intervention as inherently unnatural and unsafe. Stein asserts that:

> ... this belief underlies theories that view homosexuality as pathological as well as those that describe it as a normal variant, and notes that it serves as a central motivation within the biomedical sciences for attempting to determine the cause of homosexuality, whether this is believed to lie primarily in genetic, hormonal, environmental, or familial factors (p.88) ....
>
> The two central essentialist assumptions underlying virtually all contemporary approaches to psychotherapy with lesbians, bisexuals, and gay men today are: 1) that sexual orientation is the expression of some inner personal nature that is determined either before birth or within the first two or three years of life, and 2) that sexual orientation, although it may be denied or repressed because of social or individual forces acting against its expression (especially if it is homosexual), rarely changes throughout a lifetime (p.80).

Hart and Richardson (1981, 1984) emphasized the role of choice in deciding how to act in relation to sexual identity and the need for the therapist to distinguish between the client's

problems relating to social sex-role characteristics and those involving sexual orientation. They also describe the therapist's need to recognize the essentialist beliefs of clients about the immutability of their sexual identity. These themes emerge in the debate about sexual reorientation.

Adding more, Richardson outlined the importance of the therapist's exploring the meaning and significance of being gay for each individual and understanding that sexual identity and sexual orientation are open to change. At the same time, Richardson cautions that a wish to change sexual orientation may often arise from guilt about being homosexual and that the therapist, therefore, must fully explore the motivation for change.

Schippers (1989) describes four pragmatic approaches representing possible psychotherapist's responses to constructionism during clinical treatment:

- Exploring the meaning of homosexuality for each person in therapy.
- Exploring the possibilities and limitations associated with adopting a homosexual identity.
- Emphasizing the different ways in which an individual's homosexuality may be expressed.
- Using feelings within the psychotherapeutic transference to demonstrate the variability of the emotions that can be associated with being homosexual (p.86).

As Schipper demonstrates, despite the obstacles associated with the biomedical model, many therapists are able to integrate and navigate with patients in clinical practice between essentialist and constructionist formulations of sexuality.

The clinician's ability to integrate essentialist and constructionist formulations is, I believe, key to effective clinical work with patients struggling to resolve issues of sexual orientation and identity. These patients often present with a monocular and self-condemning view of their sexuality (either entirely essentialist or entirely constructionist) with the therapeutic task for the clinician being to move the patient to a more integrative stance. My clinical view is that each individual has an essential, core sexual orientation that may or may not have the potential to evolve over time, depending on the person, the consequences of which are socially constructed. In other words, there is an essential core with social construction operating on the margins of sexual behavior and identity. The type of sexual reorientation intervention chosen by a given clinician or patient may be impacted by their essentialist or constructionist views. Likewise, both essentialist and constructionist arguments have been made in opposition to as well as in support of reorientation interventions.

Chapter 8: A Biological Philosophy of Sexual Orientation

Debate about the biology of sexual orientations has been a recurring theme throughout the last century of medicine and psychology and no discussion on essentialist or constructionist views of sexual reorientation is able to escape a debate on the role of biology. The biological contributions to the origin of non-heterosexual orientations have long been used as the principle argument against the criminalization of non-heterosexual behavior (Schmalz, 1993) as well as in support for reorientation interventions. Research findings that appear to confirm a major biological influence on sexual orientation have been viewed as 'good news for gays' (Bailey & Pillard, 1991) and criticism of evidence of biological origins has been viewed as 'anti-gay' (Jefferson, 1993). The legitimacy of sexual reorientation research and clinical interventions has been historically supported by the discovery of evidence in support of biological determinants of sexual orientation. The rationale has historically been that the presence of a biological basis for behavior legitimizes biological research and clinical interventions directed towards correcting biological defects and misadventures. The ethical question becomes: *At what cost?*

Throughout the last 100 years, many distinguished sexologists have believed that sexual orientation has a biological or genetic basis (Pillard, 1996). In various forms, this view was shared by von Krafft-Ebing (1901), Ellis (1922), Hirshfield (1936), and Freud (1962). Ellis (1922, p.2) said: "Any theory of the etiology of homosexuality which leaves out the hereditary factor cannot be admitted."

Ellis's opinion was based on three observations: 1) homosexuality often runs in families, 2) many gay men and lesbians behave in ways we would now call 'gender atypical' during childhood and 3) homosexual desire seems, in many cases, to spring into being spontaneously, that is, it was never taught to, discussed with, or observed by the child (Pillard, 1996, p.203).

Biological Models

Three basic models are commonly used to describe the involvement of biology in sexual orientation and form the basis of clinical interventions. These are the formative experience, direct and indirect models (Byne, 1996).

Formative Experience Models

Biology, in the form of neural substrate, provides the slate upon which sexual orientation is inscribed by formative experience (Byne, 1996). This model suggests that biology might determine the developmental window during which environmental factors or social experiences impact future sexual orientation. Byne draws an analogy between sexual orientation and gender-identity. It appears that both boys and girls pass through an early developmental period of undifferentiated, over-inclusive gender-identity - that is, they exclude no aspect of experience as impossible or inappropriate to them on the basis of their sex (Fast, 1984). It also appears that there is a sensitive period for the development of a differentiated sense of gender, roughly between the ages of 18 months to 3 years (Byne, 1996). The biological factors involved in delimiting this sensitive period remain obscure.

Direct Models

Direct models rely heavily on biological evidence and statistical analysis and are often less attractive to social scientists and integrative physicians.

> Biology, in the form of genes, exerts direct influence by organizing the neural circuitry that is responsible for sexual orientation. Through their impact on protein production, genes influence hormone production, the distribution of receptors and substrates for neurotransmitters, the density of neurons, and distribution of neuronal pathways as well as all the other features that distinguish one human from another. Advanced models hypothesize that direct biological effects are probably modulated by social experiences and environmental factors, such that a predisposition might be either enhanced or suppressed by external factors. Direct models are the simplest to formulate and investigate, and as such are enticing to researchers. The future may reveal a specific gene or neurotransmitter receptor subtype that correlates strongly to sexual orientation. The potential for numerous intermediate mechanisms to explain the relationship will probably prove difficult (Byne, 1996, p.229).

Indirect Models

These models suggest that biology only indirectly influences the acquisition of sexual orientation through factors such as personality and temperament. The hypothesis is that social and environmental factors are essential to the acquisition of sexual orientation (Byne, 1996).

Prenatal androgen exposure has been associated in humans as well as other species with 'rough and tumble' play (Ehrhardt & Meyer-Bahlburg, 1991). Aversion to competitive rough and tumble play in boys is thought by many to be moderately predictive of homosexual development (Bell et al, 1981). Direct model theorists suggest that such aversion is merely the childhood expression of a brain that has been pre-wired for homosexuality (Isay, 1989), perhaps through a genetic or hormonal mechanism (Bell et al, 1981).

An indirect model interpretation postulates that the biologically influenced aversion to rough and tumble play does *not* imply pre-wiring for homosexuality. Instead, it can become a potent factor predisposing the individual to development as a homosexual in particular environments - for example, where stigmatized by family or peers as 'sissy' behavior. It would arguably have different consequences in environments where such behavior is accepted, perhaps making no contribution to sexual orientation at all (Byne, 1996, p.132).

It has been similarly conjectured that temperamental variants (for example, reward dependence, novelty seeking, and harm avoidance) could have an impact on the acquisition of sexual orientation in an interactive way (Byne & Parsons, 1993). If temperament variants were genetically determined, then homosexuality would appear heritable despite the significant influences of environment and culture (Byne, 1996).

The Unsupported Paradigm

Most biological research addressing the issue of sexual orientation is based on the direct model and the assumption that sexual orientation is a sexually dimorphic trait.

> Some researchers, therefore, expect particular aspects of an individual's brain or physiology to conform to one of two archetypes: a male type that drives sexual attraction to women and is shared by heterosexual men and lesbians or a female type, shared by heterosexual women and gay men, that causes attraction towards men. Research then seeks to demonstrate that a variety of presumed sexual dimorphisms (sex differences) are either reversed or incompletely differentiated in homosexual individuals (Byne, 1996, p.133).

This paradigm appears to be significantly contaminated by cultural prejudices. The premise that gay men are more feminine or lesbians are more masculine appears to be culturally driven. Some ancient Greek literature, for example, describes homosexual men as the most manly of men and lesbians as the most womanly of women (Hamilton & Cairns,

1961). Culturally prescribed homosexual activity on the part of young Melanesian males is described as necessary for the attainment of strength and virility (Herdt, 1984).

Hormonal Hypotheses

Since the discovery of the sex hormones (androgens and estrogens), scientists have hypothesized that plasma or brain concentrations of these hormones have an impact on sexual orientation. However, the overwhelming majority of studies failed to demonstrate a correlation between sexual orientation and adult hormonal constitution (Meyer-Bahlburg, 1984). Moreover, hormonal 'therapies' failed to change sexual orientation, and sexual orientation has not been shown to shift in adults as a consequence of alterations in hormone levels resulting from gonadal malignancies, trauma, or surgical removal (Gooren, 1990).

> In rodents, hormonal exposure in early development determines the balance between male and female patterns of mating behaviors displayed in adulthood. Specifically, female rodents that have been exposed to androgens early in development show more male-typical mounting behavior than do normal adult females. Conversely, males deprived of androgens by castration during the same critical period will subsequently mount less and display female mating posture (called 'lordosis'), when they are mounted (Goy & McEwen, 1980, p.17).

Similar hypotheses have been developed for humans, although, for obvious reasons, there have been no human experiments to investigate their validity. It is very problematic extrapolating from sexual behavior in rats to human sexuality. That rats are the only species with such overt adult consequences to changes in neonatal and prenatal hormone levels identified thus far probably argues against any comparable process in humans (Byne, 1996).

A variant of hormonal hypotheses is the *Prenatal Stress Hypothesis* which postulates that significant stress during the prenatal period impacts the hormonal milieu of the fetus and can impact future sexual orientation. A number of animal models have been presented and replicated supporting the model in both rats and mice (LeVay, 1996). Dorner et al (1980) presented data to suggest that homosexual males report that their mothers suffered significantly increased amounts of stress during pregnancy. However, numerous efforts to replicate Dorner's studies have failed to show a correlation between prenatal stress in humans and future homosexual orientation (Byne, 1996).

Human Prenatal Hormone Abnormalities

Several different medical conditions in humans are associated with low or no exposure to androgens in male newborns and excessive androgen exposure in female newborns. These syndromes and disorders account for the development of pseudohermaphroditism and the so-called 'inter-sexed' infant. For several decades, these 'inter-sexed' infants were treated with surgery to create external genitalia consistent with one sex or the other.

Research into the subsequent sexual orientation of such individuals tends to support a formative experience model. Regardless of their genetic sex or the nature of the prenatal hormonal exposure, these individuals usually become heterosexual in accordance with the sex they are assigned - provided that the sex assignment is made unambiguously and early (Meyer-Bahlburg, 1984). However, some studies have reported an increase in homosexual fantasies or behavior among women who were exposed to excess androgens as fetuses. Friedman and Downey (1993) note that these findings were not robust, and interpretation is difficult given the limitations of the experimental design and execution.

Interestingly, Hall and Kimura (1994) of the University of Western Ontario found a relationship between the number of fingertip ridges on men and their sexual orientation. They compared the number of ridges on the index finger and thumb of the left hand with the number of the corresponding fingers of the right hand. They found that 30% of the homosexuals tested had a surplus of ridges on their left hand, whereas only 14% of the heterosexuals did. This is of particular interest, because fingerprints are fully determined in a fetus before the 17th week of pregnancy, and do not change thereafter. This seems to suggest that the sexual orientation of some adult homosexuals was determined before birth, perhaps at conception, and certainly by the end of the 4th month of pregnancy (Donn, 2000).

Researchers at the University of California at Berkeley (Donn, 2000) compared the length of index fingers and ring fingers of 720 volunteers. It is well known that men's index fingers tend to be shorter than their ring fingers and that women tend to have index and ring fingers that are about the same length. They found that lesbians tended to have shorter index fingers (relative to their ring fingers) than heterosexual women. They also found that gay males tended to have shorter index fingers (relative to their ring fingers) than heterosexual males. The relative size of a person's fingers is determined well before birth, implying that sexual orientation is also at least partly decided before birth.

A group of researchers at the University of Texas found structural differences in the inner ears of lesbians and heterosexual women (Weeks, 1985b). On average, women have more sensitive cochlea amplifiers than men; they are able to detect softer sounds in a very quiet room. The researchers found that lesbians had inner ear characteristics similar to those of men. The structure of the inner ear forms before birth and is affected during pregnancy by both androgens and viral infections.

Prenatal viral and bacterial infections as well as pharmaceuticals, chemicals and toxins have been tied to a number of overt clinical conditions that begin in utero. Examples include fetal alcohol syndrome, congenital rubella, congenital syphilis, and thalidomide associated phocomelia. Prenatal, postnatal and childhood exposures to these environmental agents have been posited as potential origins for a variety of conditions that appear on the surface to have roots in both genetic risk and environmental exposure. Schizophrenia, bipolar disorder, juvenile onset diabetes, and a variety of autoimmune disorders have been investigated for potential environmental exposures as catalysts to the development of the condition. An argument could easily be made to support such a hypothesis in the case of homosexuality and a variety of sexual fetishes.

Immune Hypothesis

T. Binstock introduced an immune hypothesis in November of 2001:

> Sexual orientation is encoded within immune cell subsets (ICS) of mucosal and epithelial tissues. Gender orientation may be encoded within other ICS. Many immune cells recognize and react to H-Y and H-X antigens and enact these perceptions and reactions in accord with the perceiver's and the perceived's MHC haplotype, XX or XY status, and immune self recognition. Non-heterosexual orientations derive from excessive cross priming, accompanied by clonal deletions, clonal expansions, anergy, and tolerance. For at least some tissues, cross priming sufficient to induce altered orientations occurs during critical periods of immunological development and can occur during fetal and infant development via maternal-fetal transfusion, placental pathology, and impaired maternal nutrient-status or via excessive peripheral apoptosis during postnatal illness. Most cell interactions with neurons illustrate how mucosal perceptions can be transduced into neuronal signals that modulate central nervous system events. This hypothesis is testable by mixed-lymphocyte reactions in appropriate cell subsets. Dendritic cell immunizations are thought to be a potential therapy. (pp. 583-584)

Although still very much in the hypothetical stage, this immunological hypothesis offers a multi-dimensional view that suggests a potential diversity of phenotypic expression of sexual orientation. This could account for homosexuality, bisexuality, fetishes, and a multitude of heterosexual behaviors (kinks) that can be difficult to explain in psychological terms.

Neuroanatomy

Gorski et al (1978) described a neuroanatomic structure in rats five to eight times greater in males than in females. This structure, known as the sexually dimorphic nucleus of the preoptic area (SDN-POA), was found to decrease mounting behavior on destruction and increase mounting behavior on stimulation (Slimp et al, 1978). With similar findings in other laboratory species, the preoptic area has been proposed as the site that regulates male sex behavior in mammals (Byne, 1996).

A much popularized study by Le Vay (1991) at the Salk Institute in California identified the INAH3 nuclei in the anterior hypothalamus as being significantly larger in men than in women and gay men with AIDS. Studies with other species indicate that the SDN-POA site size is dependent on androgen levels. Le Vay's study is criticized for using gay men who later died of AIDS, a group that routinely has very low testosterone levels as part of the disease process and as a consequence of treatment. Other criticisms include the inability to replicate the study findings.

The suprachiasmic nucleus (SCN) has been reported to be larger in homosexual men than in heterosexual individuals with no statistical difference between men and women (Swaab & Hoffman, 1990). Like Le Vay's work, this study has not been replicated and gay men who subsequently died from AIDS were used as the homosexual controls.

Brain commissures and the corpus callosum have been examined extensively for evidence of differential size with relation to gender and sexual orientation. However, the reliability of these studies also suffers the same difficulties as the hypothalamic studies; male AIDS victims were used for the homosexual controls and none of the studies are predictably replicable.

Genetics

Henry (1941) published extensive case material on 40 male and 40 female 'sex variants' (mostly homosexual). Pillard et al (1981) tabulated the frequency of homosexuality in

siblings from the family trees of Henry's studies and concluded that 10.6% of the brothers and 7.7% of the sisters of the sex variants were also homosexual, a much higher percentage than would occur in a random survey of the population (Pillard, 1996). Of note is that of the 12 homosexual or bisexual aunts and uncles in Henry's kin, 11 came from the maternal lineage (Pillard, 1996). Henry's study also documents numerous scattered reports of families with dense clusters of homosexual members, markedly exceeding chance.

Pillard et al (1982), Pillard and Weinrich (1986) demonstrated that gay male probands had a considerable excess of gay and bisexual brothers but no excess of lesbian sisters when compared to heterosexual men. A similar study revealed a trend for lesbians to have more lesbian sisters and a few more gay brothers than their heterosexual peers (Pillard, 1988).

Pillard (1996) identified a sibship of three brothers and four sisters in which all three brothers were homosexual or bisexual and three of the four sisters were homosexual. The odds that such a sibship could occur by chance depends on the frequency of male and female homosexuality in the population; the more common homosexuality is, the less remarkable a family with multiple homosexual siblings. With the use of conservative assumptions, Pillard calculated the odds to be about 1 in 100 million.

A high degree of concordance (50%) for homosexuality in identical (monozygotic) twins has been reported on numerous occasions (Green & Stoller, 1971; Heston & Shield, 1968; Kallman, 1952; Mesnikoff et al, 1963; Parker, 1964; Pillard et al, 1981; Puterbaugh, 1990; Rainer et al, 1960). Bailey and Pillard (1991) and Bailey et al (1993) report a 52% concordance rate for male identical twins and 48% concordance for female identical twins, a 22% concordance for dizygotic and non-twin brothers and a 16% concordance for dizygotic twin sisters and non-twin sisters, an 11% concordance rate for adopted brothers and 6% for adopted sisters. The concordance rates for adopted siblings (11% and 6%) are higher than the incidence in the general population, suggesting some environmental contribution. These statistics suggest that a combination of genetic and environmental factors contribute - a mix of nature and nurture in predicting sexual orientation. The ideal scenario would be to study a cohort of identical twins separated at birth, but unfortunately the numbers of such events occurring naturally are too small to provide meaningful research material.

Hamer et al (1993) of the National Cancer Institute (Washington, DC) successfully demonstrated a genetic linkage of the q28 region at the tip of the long arm of the X-

chromosome in 33 of 40 pairs of gay brothers who had other gay relatives related through the maternal lineage. Although yet to be replicated; this study offers molecular geneticists a specific gene locus to investigate. With recent advances in human genome technology, it is likely that allelic associations will demonstrate multiple gene sites interacting, which impact sexual orientation in a variety of ways. These studies will require large numbers of control and study subjects (Plomin et al, 1994).

Rice (1995), a neurologist at the University of Western Ontario, conducted a test that contributes a new dimension to the Hamer study. He studied 46 families with 2 gay brothers, and 2 families with 3 gay brothers. They weren't selected on these grounds alone, however, but because a pedigree test was the reverse of the Hamer study. In the case of Rice's subjects, homosexuality was present mostly on their father's side of the family, and not the mother's. As a male's X chromosome is inherited only from his mother, and as there were few or no gays on the mother's side among Rice's subjects, it would appear that sexual orientation was not caused by the genes on the chromosomes. If there were any 'gay-causing' genes among the 98 subjects, they would have to be elsewhere than the X chromosome. As anticipated, from his special group of subjects, Rice was unable to replicate Hamer's findings of common sequences on the X chromosome.

One theory holds that the penetrance of the 'gay gene' is approximately 67%; in other words, when the 'gay gene' is present there is a 67% chance of the carrier being gay (Weeks, 1985). Assuming this to accurate, one would expect that when one fraternal twin is gay the other would also be gay about 22% of the time. This would also be consistent with studies of identical twins (Weeks, 1985).

Ecological Genetics

Another aspect is described by Plomin et al who note that if shared environment (e.g. the family's socioeconomic level) contributes to the variance in sexual orientation, we should observe a lesbian or gay orientation as frequently in adopted as in biological siblings, as they all share the same family situation. Studies of other behavioral traits point in the same direction; different environmental influences tend to make children in the same family differ rather than otherwise.

Kirsh and Weinrich (1991) raise the question of the evolutionary significance of genes promoting non-heterosexuality. It has been suggested that non-heterosexuality must have been favorably selected at some point in human evolution because it is far too common to be the result of accidental mutations, which would otherwise be removed by the natural process of selection. A mechanism for the conservation of gay genes is a subject for significant debate and future research.

Evolutionary geneticists raise the question of gene value, noting that in a wide variety of cultures, gender variant individuals play special roles as shamans, mediators, artists, helpers and so on. It has been suggested that these genes persist because of their value to the community (LeVay, 1996).

Alcock (1984) describes one possibility as 'kin altruism', referring to individuals who help relatives survive and reproduce at the expense of their own reproductive potential. An example from nature is that of the lion pride. Larger prides are most successful in patrolling the territory and protecting the cubs when there are 4 or more male lions (usually brothers). Although one would assume that all four males would be reproducing at the same rate, DNA fingerprinting reveals that one or two males sire most of the cubs and some males sire none. Because the males are closely related, the genes of the non-reproducing male get passed to the cubs via a brother (Pillard, 1996).

One way to look beyond the immediate value of a gene-mediated trait to the reproduction of its owner is to ask whether the gene confers any reproductive benefit on heterozygous carriers (Hutchinson, 1981). Sickle cell anemia is a classic example. When two heterozygous adults mate in a population where the sickle cell gene is prevalent, 50% of the offspring are afforded protection against malaria, 25% of the offspring go unprotected and 25% of the offspring suffer the shortened life-span caused by active sickle cell anemia. It has been hypothesized that the heterozygous state provides some special, obscure benefits and that homozygous states result in increased homosexuality and decreased reproductive outcome.

Mainstream scientific opinion continues to hypothesize that there are probably multiple forms of homosexuality and bisexuality with multiple biological origins related to several gene loci which interact in some cases to direct future sexual orientation and in others to facilitate environmental determinants of future sexual orientation.

Infectious Hypothesis

Biologist Paul Ewald and physicist Gregory Cochran theorize, with indirect reasoning, that homosexual orientation may be caused by exposure to bacteria or a virus (Crain, 1999).

Any genetic trait that reduces a person's chance of procreation is said to have a 'fitness cost'. A trait that has a 'fitness cost' of 1% lowers the probability of having children by 1%. In this case, the trait would essentially disappear within 100 generations. Homosexuality has a 'fitness cost' that is much higher than 1%. A 1981 study in San Francisco showed that gays and lesbians have only 20% as many children as heterosexuals. In other words, the fitness cost factor among that sample of homosexuals is 80%. This number was probably much lower in the past, as gays and lesbians were forced into marriages in order to escape detection. Since homosexuality has not disappeared but seems to have a high fitness cost, the researchers speculate that the trait is at least partly determined by some outside agent, such as infection (p.9).

Aside from the fact that no infectious agent has even been theoretically indicated, much less found, it is a fact that infections tend to peak in a few geographical areas for limited duration and there are no obvious concentrations of gays and lesbians who grew up in the same area or who are all nearly the same age. One can also criticize the theory by suggesting that homosexuality may have sufficient advantage to overcome its fitness cost.

The above provides a small cross section of a variety of biological explanations for homosexual behavior and desire. Some of the research is flawed in its design, some flawed by the prejudices of the researchers, other experiments have failed to be replicated, while some await replication, and many are just hypothetical cases. Criticism of the biological studies mirrors that of psychological explanations, in that the beliefs and values of the researchers often determine the direction of the research.

With the explosion of research not yet in fruition from the human genome project, I anticipate a biological explanation that describes several pathways leading to the potential phenotype for a non-heterosexual adult sexuality including a biogenetic path for an evolving sexual orientation over time. I believe a role for human pheromones will be discovered, not just for adult interactions but also for imprinting on the brain a template for future objects of sexual desire in children and perhaps adolescents. Such a system would lend itself to impact by both biology and environment, across the lifespan.

Chapter 9: A Psychological Philosophy of Sexual Orientation

Psychology and psychiatry have been the driving clinical force behind sexual reorientation interventions since the medicalization of sexuality and non-heterosexuality in particular that occurred in the late 1800s. An appreciation of the evolution of psychological and psychiatric thought on sexual orientation is key to a critical analysis of this ethical debate. Many of the stakeholders throw out as fact concepts that reflect social construction and not science.

Early Scientific Theories

In his *Outlines on the Lectures of Mental Disease*, prepared in 1825, Sir Alexander Morrison wrote that:

> *Monomania with Unnatural Propensity* is a variety of partial insanity, the principal feature of which is an irresistible propensity to the crime against nature. This offense is so generally abhorred, that in treatise upon law it is termed *'peccatum illud hooibile inter Christianas non nominandum'*. ... Being of so detestable a character it is a consolation to know that it is sometimes the consequence of insanity; it is however, a melancholic truth that the offense has been committed in Christian countries by persons in full possession of their reason and capable of controlling their actions (p.2).

Only in the last half of the nineteenth century did homosexuality become the subject of concerted scientific investigation (Bayer, 1987). Carl Westphal, a professor of psychiatry in Berlin, is credited with having placed the study of homosexuality on a clinical, scientific footing when he published a case history of a female homosexual in 1869. Terming her condition 'contrary sexual feelings', he concluded that her abnormality was congenital rather than acquired. Westphal went on to study more than two hundred such cases, developing a classification of the variety of behaviors associated with homosexuality (Bullough, 1977).

In France, the Director of the Salpetriere, Charcot, also concluded that homosexuality was inherited after failing to effect a cure through hypnosis (Bayer, 1987). So far as his colleague Moreau was concerned, homosexuality was the outcome of an inherited *constitutional weakness* and *environmental forces* (Bullough, 1974). Most important of the late nineteenth century students of sexual deviance was Von Krafft-Ebing, whose monumental *Psychopathia Sexualis* had an enormous impact on informed opinion about homosexuality and emphasized both inherited and acquired origins (Bayer, 1987).

Cesar Lombroso, the late nineteenth century Italian criminologist, argued that homosexuals represented a lower stage of development than heterosexuals:

> Though the human race had evolved over eons, leaving behind its own primitive behavior, each child was required to recapitulate the process in the course of its own development. Those with defective heredity failed to complete that process and remained at a less civilized point in the evolutionary course (1883, p.8).

Since homosexuals could not, in Lombroso's view, be held responsible for their own failure, no justification existed for their punishment (Bayer, 1987). However, social defense required that they be restricted to asylums because of the danger they posed (Bayer, 1987).

Karl Ulrichs, one of the most prolific defenders of homosexuals in the late nineteenth century, asserted in the 1860s that homosexuality was a hereditary anomaly: "While the genitals of homosexuals developed along expected lines, their brains did not, and so it was possible for a female soul to be lodged in a male's body." These views anticipated those of Havelock Ellis, whose work *Sexual Inversion* sought to demonstrate that homosexuality was inborn, and therefore, natural. Finally, Magnus Hirschfeld, the great German advocate of homosexual rights, held that homosexuality was not pathological but the result of inborn characteristics determined by glandular secretions (1871).

Bayer (1987) emphasizes that the discoveries of the late nineteenth century did little to frame an understanding of homosexuality, stressing that the perspective on homosexuality determined the meaning of those facts. This is a phenomenon that reverberates throughout gay and lesbian philosophy.

Psychoanalysis

For Freud, as for most of those who undertook scientific study of sexuality in the late nineteenth and early twentieth centuries, the idea that heterosexuality represented the normal end of psychosexual development (Bayer, 1987) went without question. Freud maintained that, despite the complex and uncertain process of maturation, " ... one of the tasks implicit in object choice is that it should find its way to the opposite sex" (Freud, 1962, p.123).

In Freud's attempt to explain sexual inversion, he set himself in sharp opposition to those scientists who claimed that homosexuality was an indication of degeneracy. Instead, he asserted that such a diagnosis could only be justified if homosexuals typically exhibited a

number of serious deviations from normal behavior and if their capacity for survival and 'efficient functioning' was severely impaired (Freud, 1962). This perspective distinguished Freud from many of his earliest followers as well as from later psychoanalytic philosophers who saw in homosexuality a profound disturbance affecting every aspect of social functioning (Bayer, 1987).

While many early psychoanalytic organizations and institutions sought to ban homosexuals from psychoanalytic training and professional memberships, Freud rejected these suggestions, saying:

> In effect we cannot exclude such persons without other sufficient reasons, as we cannot agree with their legal prosecution. We feel that a decision in such cases should depend upon a thorough examination of the other qualities of the candidate (Freud & Rank, 1922, p.9).

To a similar suggestion by the Berlin psychoanalytic society, Freud responded that while barring homosexuals from psychoanalytic work might serve as something of a 'guideline', it was necessary to avoid a rigid posture since there were many types of homosexuality as well as quite diverse psychological mechanisms that could account for its existence (Freud & Rank, 1922).

Freud characterized homosexuality as a natural feature of human psychosexual existence, a component of the libidinal drives of all men and women. According to his beliefs, all children passed through a homosexual phase in their psychosexual development, on the route to heterosexuality. Even in those who advanced successfully beyond the earlier phase of development, however, homosexual tendencies remained (Bayer, 1987): "The homosexual tendencies are not ... done away with or brought to a stop. They were rather deflected from their original target and served other ends" (Freud, 1963, p.163). For Freud, social instincts such as friendship, *camaraderie*, and 'general love for mankind' all derived their strength - their erotic component - from the unconscious homosexual impulses of those who had achieved the capacity for heterosexual relations (Bayer, 1987).

The capacity for both homosexual and heterosexual love was linked by Freud to what he believed was instinctual, constitutional bisexuality. Activity, passivity, and the desire to introduce a part of one's body into that of another or to have a part of another body introduced into oneself, and finally masculinity and femininity, were all reflections of bisexuality (Fenichel, 1945). At times the active, masculine drives dominated, at others the feminine,

passive drives did. In no case was a person utterly without both sets of drives. Just as with homosexual impulses, the repressed was not obliterated. Even in adults who had traversed the course to heterosexuality, masculine and feminine impulses coexisted (Freud, 1970).

Freud set forth a number of explanations for the perversion of the normal course of psychosexual development resulting in an exclusively homosexual adult male. The classical mechanisms discovered during his psychoanalytic work stressed a number of possibilities, any one of which might determine a homosexual outcome. Regardless of the specific factors involved, however, all started from the assumption that exclusive homosexuality represented an arrest of the developmental process, an instinctual fixation at a stage short of normal heterosexuality (Bayer, 1987).

Among Freud's first formulations on the etiology of homosexuality was one that focused on the male child's attachment to his own genitals as a source of pleasure. Like all boys, those who are destined to become homosexual find in the penis a source of enormous pleasure. Freud believed, however, that in future homosexuals there was an inborn 'excessive' interest in their own genitals during the autoerotic phase of psychosexual development: "Indeed it is the high esteem felt by the homosexual for the male organ which decides his fate" (Freud, 1971).

Later, Freud (1962) asserted that homosexuality was linked to the profound frustration experienced during the Oedipal phase by those boys who had developed especially intense attachments to their mothers. Denied the sexual gratification they longed for, these boys regressed to an earlier stage of development, and identified with the woman they could not have. They then sought young men who resembled themselves as sexual partners and loved them in the way that they wished they themselves had been loved by their mothers (Bayer, 1987).

According to Fenichel (1945), in those cases where an intense attachment to the mother was combined with a fixation upon the erotic pleasures of the anus, the dynamics were somewhat different. In these instances, a desire to receive sexual gratification from the mother was transformed into a wish to enjoy sex in the way she did: "With this as a point of departure, the father becomes the object of love, and the individual strives to submit to him as the mother does, in a passive-receptive manner" (Fenichel, 1945, p.12).

While Freud saw the child's attachment to the mother as pivotal in most cases, he was careful to note instances in which the father and other male figures played a central role in the etiology of homosexuality (Bayer, 1987). In some cases, the homosexual outcome could be determined by the absence of the mother. Deprived of a woman's presence, the young boy might develop a deep attachment to his father or another older male and consequently later seek someone reminiscent of the primary object of his love in his sexual partners. Alternatively, homosexuality could be accounted for in terms of the fear of the anger aroused in his father by the son's Oedipal strivings. Terrified by the prospect of his father's retaliatory rage, the young boy could be forced to withdraw from his intense attachment to his mother. Having in this instance chosen to 'retire in favor' of the more powerful male, such a boy would then abandon women entirely. Thereafter only a homosexual attachment could provide sexual gratification without anxiety about castration (Freud, 1971).

Finally, a later speculation of Freud's suggested yet another formulation in the etiology of homosexuality involving a powerful male (Bayer, 1987). In this case, an older male sibling was crucial. Jealousy derived from intense competition for the mother's attention generated murderous impulses in the younger boy, and partly because of training, but more importantly because the boy recognized his own relative weakness, he was forced to repress those wishes. Transformed in the process, they would then express themselves as homosexual love for the formerly hated brother (Freud, 1922).

Running throughout Freud's efforts to identify the roots of homosexuality was a complex series of combinations of inherited, 'constitutional' factors and environmental or 'accidental' influences (Bayer, 1987). To Freud, the fact that not everyone subjected to similar influences became homosexual suggested that biological forces played an important role (Freud, 1962). Confronted by an extraordinary richness of detail in his case studies, Freud (1963, p.320) remarked that he had uncovered a " ... continual mingling and blending" of what in theory "we should try to separate into a pair of opposites - namely, inherited and acquired factors."

As a theoretician, Freud (1922, p.13) was committed to the proposition: "that all psychic phenomena were determined by antecedent forces beyond the individual's control." This determinism, as well as his own more generous attitude toward the basic instinctual drives of human beings, made him so unalterably opposed to the rigid, condemnatory stance towards homosexuals of the society in which he lived. That same determinism made his work an

anathema to those whose world-view demanded that individuals be held to account for deliberate violations of what were then considered civilized sexual standards (Bayer, 1987).

Freud was especially pessimistic about the prospects for the psychoanalytic cure of homosexuality: "One must remember that normal sexuality also depends upon a restriction in the choice of object; in general, to undertake to convert a fully developed homosexual into a heterosexual is not much more promising than to do the reverse, only that for good practical reasons the latter is never attempted" (Freud, 1922, p.45). At the basis of this profound limitation of his own technique was his belief that the cure of homosexuals involved the conversion of one "variety of genital organization of sexuality into the other" rather than the resolution of a neurotic conflict (Freud, 1922, p.44).

Unlike the neuroses, which were a source of pain and discomfort, homosexuality was a source of pleasure: "Perversions are the negative of neuroses" (Freud, 1962, p.12). To treat a homosexual successfully would necessitate convincing him that if he gave up his current source of erotic pleasure he could again "find the pleasure he had renounced" (Freud, 1962, p.27). Aware of how difficult it was for neurotics to change, Freud was unable to strike a positive therapeutic stance with respect to homosexuality (Bayer, 1987). Only where the homosexual fixation was relatively weak, or where there remained "considerable rudiments and vestiges of a heterosexual choice of object" was the prognosis more favorable (Freud, 1922, p.34).

Freud's therapeutic pessimism, as well as his acknowledgment that many homosexuals, though arrested in their development, could derive pleasure from both love and work provides the context in which his compassionate and now famous *Letter to an American Mother* of 1933 was penned:

> *Dear Mrs...*
>
> *I gather from your letter that your son is a homosexual. I am most impressed by the fact that you do not mention this term yourself in your information about him. May I question you, why you avoid it? Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michaelangelo, Leonardo Da Vinci, etc.). It is a great injustice to persecute homosexuality as a crime, and cruelty too. If you do not believe me, read the books of Havelock Ellis.*

> *By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies that are present in every homosexual, in the majority of cases it is no more possible. It is a question of the quality and the age of the individual. The result of treatment cannot be predicted.*
>
> *What analysis can do for your son runs in a different line. If he is unhappy, neurotic, torn by conflict, inhibited in his social life, analysis may bring him harmony, peace of mind, full efficiency whether he remains homosexual or gets changed ...*
>
> *Sincerely yours with kind wishes,*
> Freud. (1957)

In the search for an early developmental disturbance in homosexual women, Ernest Jones (1927, p.23) asked: "What differentiates the development of homosexual from that of heterosexual women?" As psychoanalytic theory expanded from drive theory through ego psychology and object-relations models, various answers to Jones' question emerged. The specific disturbance of early development said to characterize women with homosexual feelings or lesbian relationships have included the following:

- A disorder of drive/object caused by penis envy at the Oedipal stage, which leads to a repulsion towards heterosexual relations and a regression to a fixation to an earlier object (Fenichel, 1945, Freud, 1920).
- A disordered identification with the father in which identification replaces object relationship (Freud, 1920; Jones, 1927), or an identification with the father in order to prevent psychotic symbiosis with mother (McDougal, 1970).
- Failed identification with mother due to maternal envy (Freud, 1920/1955) or maternal narcissism (Siegal, 1988) or the masochistic debasement of the life of mother (Romm, 1965).
- A disturbance of early (mother/child) object relations characterized by masochism (Brierley, 1932; Deutsch, 1948; Socarides, 1978) or failed separation-individuation (Socarides, 1968).
- A premature genital awareness (Khan, 1964); a precocious turn-on of erotic desire which "occurs when the child has been excluded from 'good enough' or 'long enough' primary bliss and seeks inclusion by a sexual bond and sexual wooing" (Eisenbud, 1982, p.32).

Marmor (1980), Herdt and Stoller (1985) took exception to attempts to find a common psychodynamic denominator in female homosexuality. Instead, they stressed the multi-determined nature of any psychic phenomenon and pointed to the prejudices embedded in psychological theories about homosexuality in women.

Rado, Bieber & Socarides

Though some analysts were more sanguine, Freud's pessimism regarding the potential of a therapeutic reversal of homosexuality dominated psychoanalytic thinking for almost forty years (Bayer, 1987). A marked shift took place in the 1940s, influenced in large measure by the work of Sandor Rado and his adaptational school of psychoanalysis.

In Rado's view, Freud had made a fundamental error in assuming that the ambiguous sexuality of the zygote implies the presence of both male and female attributes in the psyche. This, he declared, was an "arbitrary leap from the embryological to the psychological" (Kardiner et al, 1959). Unduly influenced by the ancient myth of the unity of male and female, Freud had failed to understand that:

> ... the sexes are an outcome of evolutionary differentiation of contrasting yet complementary reproductive systems. Aside from the so-called hermaphrodite ... every individual is either male or female. The view that each individual is both male and female (either more male or less female or the other way around) ... has no scientific foundation (Rado, 1962, p.62).

Rado went on to assert that, while biology dictated the appropriate nature of sexuality, humans did not inherit biological directives regarding the use of their sexual organs. Instead, the remarkable inventions of culture supplied the requisite instructions.

For Rado, homosexuality represented a 'reparative' attempt on the part of human beings to achieve sexual pleasure when the normal heterosexual outlet proved too threatening. While fear and resentment could thwart the natural expression of heterosexual desire, they could not destroy it - only schizophrenic disorganization could achieve that end (Rado, 1962).

Having explained homosexuality as a phobic response to members of the opposite sex rather than a component of human instinctual life, and having assumed the ever-present existence of a strong heterosexual drive, Rado and his followers were able to adopt a more positive therapeutic stance. This new optimism, conveyed primarily through the work of those at Columbia University's Psychoanalytic Clinic for Training and Research, began to

affect the theoretical and clinical work of a number of psychoanalysts who became prominent during the 1960s, when the status of homosexuals became an issue of great social concern (Bayer, 1987).

Bieber (1962) noted that all psychoanalytic theories assume that homosexuality is pathologic and explicitly rejected the Freudian assumption of constitutional bisexuality and an innate homosexual drive, emphasizing instead that exclusive heterosexuality was the biological norm. He set out to reverse the classical psychoanalytic belief in the presence of a latent homosexual drive in all heterosexuals and asserted that, "every homosexual is a latent heterosexual (p.43)."

Having rejected the possibility that constitutional factors could account for the development of homosexuality, Bieber turned to an analysis of the families of the patients described in the New York Psychoanalytic Society's sample of homosexuals undergoing treatment (Bayer, 1987): "Our findings point to the homosexual adaptation as an outcome of exposure to highly pathologic parent-child relationships and early life situations" (Bieber, 1962, p.2).

> Mothers who were excessively protective and intimate were believed to have thwarted the normal development of their sons by responding to their heterosexual drives with hostility, often expressing demasculinizing and feminizing attitudes, interfering with the father-son relationship by fostering competitiveness, often favoring their sons over their husbands, inhibiting the development of normal peer relationships with other boys and damaging the capacity for independent action, subverting every sign of autonomy (Bieber, 1962, p.23).

For Bieber, the picture with regard to paternal relationships was equally bleak: " ... profound interpersonal disturbance is unremitting in homosexual father-son relationships," and though relationships between the heterosexual controls and their fathers were often "not normal," they were generally "far more wholesome" (p.25).

As a group, the fathers of homosexuals were depicted as detached, hostile, minimizing, and openly rejecting (Bayer, 1987). By failing to meet their sons' needs for affection, they created a pathological need that could be satisfied only by other males through homosexual adaptation (Bieber, 1962).

According to Bieber:

> ... the pathological basis of homosexual adaptation precludes a stable and intimate relationship. Fear of intimacy combined with a fear of retaliation on the

> part of other excluded males make homosexual couples relatively volatile. The hostility and competitiveness of such relationships bring to even the most apparently satisfactory among them a quality of ambivalence leading ultimately to impermanence and transience, hence the ceaseless, compulsive, and often anonymous pattern of homosexual cruising. (p. 35)

It is curious that Bieber speculated that an inborn olfactory sense (pheromones) may act as a steering mechanism guiding both men and women to the opposite sex, although he failed to hypothesize a disorder of receptors for the pheromones in homosexuals (Bayer, 1987). Socarides, like Bieber, became a leading force in American psychiatry of the late 1960s and early 1970s, characterizing homosexuality as a profound psychopathology. Heterosexual object choice is determined by two and a half billion years of human evolution, a product of sexual differentiation (Socarides, 1974). Socarides rejected pheromones' role and argued that both homosexuality and heterosexuality are learned behaviors (Bayer, 1987).

> Heterosexual object choice is outlined from birth according to a child's anatomy and then reinforced by cultural and environmental indoctrination. It is further reinforced by universal human concepts of mating and the traditions of the family unit, together with the complementary nature of and contrast between the two sexes. Everything, from birth to death, is designed to perpetuate the male-female duality. This pattern is not only culturally ingrained, but anatomically outlined. The term 'anatomically outlined' does not, however, mean that choosing a person of the opposite sex is an instinctual matter. The human being is a biologically emergent entity derived from evolution, favoring survival (Socarides, 1974, p.291).

Socarides shared Rado and Bieber's view that homosexuality could be explained only in terms of 'massive childhood fears' that disrupted what human evolution had decreed to be the normal course of development (Socarides, 1975). His major contribution to psychoanalytic theory of homosexuality has been the suggestion that the disturbance responsible for those fears occurred much earlier in life than other formulations inferred (Bayer, 1987), being pre-Oedipal rather than Oedipal in origin:

> The failure to successfully transverse the stage of development that occurs before the age of three years, at which point the child is believed to establish an identity separate from that of the mother (the separation-individuation phase), has dire consequences. In the case of the male child, remaining pathologically bound to the mother precludes the emergence of an appropriate gender-identity. Consequently, all 'true' or 'obligatory' homosexuals are characterized by a feminine identification, and any effort to establish a relationship with a woman other than the mother produces profound separation anxiety, while producing a

> terrifying dread of potential engulfment and loss of the self" (Socarides, 1969, p.202).

According to Bayer:

> Socarides established a theoretical justification for characterizing homosexuality as more profoundly pathological than it was generally considered to be when Oedipal conflicts were stressed, by pushing the etiology of homosexuality back to the pre-Oedipal phase of development (p.204).

The desperate and compulsive search for sexual partners assumed to be part of gay life is interpreted as grasping for a sense of an ever-elusive masculinity, protecting the homosexual from his fear of merging with his *pre-Oedipal mother*: "They hope to achieve a 'shot' of masculinity in the homosexual act. Like the addict [the homosexual] must have his 'fix' (Socarides, 1970, p.212).

> Despite the prominence gained by the likes of Socarides and Bieber in the 1960s and 1970s, American psychoanalytic formulations and psychoanalytic interventions remained remarkably diverse, even though everyone agreed that homosexuality was pathological. When the dominance of psychoanalytic theory in American psychiatry began to wane in the 1960s, other schools of thought incorporated the view that homosexuality was an abnormality with considerable ease. For behaviorists, homosexuality was simply transformed from a perversion of the normal pattern of psychosexual development into the 'maladaptive consequence' of 'inappropriate learning' (Bayer 1987, p.196).

Bayer notes that the virtual unanimity regarding the pathological status of homosexuality was strikingly underscored by Karl Menninger in his 1963 introduction to the American edition of the British Wolfenden Report. That report, which had gained international attention by calling for the decriminalization of homosexual activity between consenting adults, rejected the classification of homosexuality as a disease (Wolfenden Report, 1963). Applauding its criminal law recommendation, Menninger (1963) ignored the latter point, writing:

> From the standpoint of the psychiatrist, homosexuality constitutes evidence of immature sexuality and either arrested psychological development or regression. Whatever it be called by the public there is no question in the minds of psychiatrists regarding the abnormality of such behavior (p.1).

Reparative and Conversion Therapies

The origins of modern-day secular reparative therapy can be traced many decades back to the research of Bieber, Hatterer, and Freud. Moberly, a conservative British Christian theologian, studied their works and developed a new theory for the cause of homosexuality - the hypothesis that it is caused solely by environmental factors, or incompetence on the part of the parent of the same gender.

She abandoned Freud's emphasis on the domineering mother, focussing instead on the effect of the 'passive' or 'distant' father. Moberly determined that the homosexual men in her studies were suffering from what she termed 'defensive detachment' and 'same sex ambivalence'. Her hypothesis assumes that the young boy, for any of a variety of reasons, did not bond with his father in a meaningful way. Feeling the lack of a positive relationship with his father, the boy 'defensively detaches' from any potential friendships with other boys of his age. After puberty, he redirects his longing for a close relationship with his father and other males towards a search for love. The longing is sexualized and manifested as attraction to other men, and the subject becomes an active homosexual.

The theory that inadequate or nonexistent fathering is a factor in the development of male homosexuality is not supported by the fact that when fathers are absent, as often occurs during wartime, a dramatic increase in the incidence of male homosexuality is not noted. Nor do societal sub-cultures with a high incidence of single-parent families and absent fathers such as the Afro-Americans of the twentieth century register higher rates of homosexuality than the norm.

Joseph Nicolosi, co-founder of NARTH, together with a number of his colleagues, such as van den Aardweg, have expanded upon Moberly's theories to formulate the most popular versions of reparative and conversion therapies available in America since the late twentieth century.

The first of seven principles postulated is the central theme of the homosexual's unconscious self-pity, perceived as a strong autonomous rumination propelling the masochistic behavior inherent in homosexuality. Homosexual desire is said to reside in this unconscious self-pity together with feelings of gender inferiority (van den Aardweg, 1997). This view neatly combines the notions and behavioral observations of Adler (1930) (that inferiority complex and compensation wishes focus the individual on the 'reparation' of

inferiority), with those of Austrian-American psychoanalyst Bergler (1957) (homosexuality as 'psychic masochism'), and of Dutch psychiatrist Arndt (1961) (concept of compulsive self-pity).

The second principle maintains that, because of his masculinity/femininity inferiority complex or gender inferiority complex, the homosexual remains in part 'a child', or 'a teenager'. This observation is known as 'psychic infantilism' (van den Aardweg, 1997). William Stekel (1922) has emphasized this Freudian notion of homosexuality, which is in line with the more recent concept of 'the inner child' (Missildine, 1963; Harris, 1973).

Thirdly, more or less specific parental attitudes and parent-child relationships may predispose individuals to the development of homosexual gender inferiority complexes (van den Aardweg, 1997). This view synchronizes with those of neo-psychoanalysts Horney (1950) and Arndt (1961) and of self-image theorists such as Rogers (1951).

Fourthly, fear of the opposite sex is frequent (Ferenczi, 1914; Fenichel, 1945) but not a primary cause of homosexual inclinations. Rather, this fear is symptomatic of gender inferiority feelings, which can be activated by members of the opposite sex, who appear to demand fulfillment of the expected sex roles that the homosexual feels unable to perform (van den Aardweg, 1997).

Fifthly, giving in to homosexual wishes creates a sexual addiction (van den Aardweg, 1997). Persons who have reached this stage essentially have two problems: their gender inferiority complex and a relatively autonomous sexual addiction (a situation comparable to that of a neurotic with a drinking problem). This is also known as the double syndrome of 'pleasure addiction' (Hatterer, 1980).

Sixthly, in self-therapy, a special role is given to self-humor. Here we see Alder's notions of self-irony, Arndt's of 'hyper-dramatization', and to a lesser degree those of behavior therapist Stampfl's (1967) regarding 'implosion', and Victor Frankl's (1975), regarding 'paradoxical intention'.

Lastly, insofar as homosexual desires are rooted in self-centeredness or immature 'egophilia' (Murray, 1953), self-therapy emphasizes the acquisition of those human and moral virtues that have a 'de-egocentric' effect and enhance the capacity for heterosexual love (van den Aardweg, 1997).

Learning Theory and Behavioral Therapy Models

Behavioral therapy, or behavioral modification, is based on the assumption that emotions and desires - like any behavior - are learned responses to the environment and can therefore be unlearned. Behavioral therapy, or behavioral modification, trains individuals to replace undesirable behaviors with healthier behavioral patterns. Unlike psychodynamic therapies, it does not focus on uncovering or understanding the unconscious motivations that may or may not be behind the unwanted behavior. In other words, therapists who are strictly behavioral don't try to find out why their patients behave the way they do. They just teach them to change their behavior using systems of reward and punishment of a type that has been employed throughout recorded history in an attempt to influence behavior, from rearing children to the treatment of criminals within the justice system.

Modern behavioral therapy began in the 1950s with the work of Skinner and Wolpe. Wolpe treated patients who suffered from phobias with a technique he developed, called 'systematic desensitization'. This involves gradually exposing a patient to anxiety-provoking stimuli until the anxiety response has been extinguished, or eliminated.

Skinner introduced a behavioral technique he called 'operant conditioning'. This is based on the idea that an individual chooses his behavior on the basis of past experiences of the consequences of that behavior. If a behavior was associated with positive reinforcements or rewards in the past, the individual will choose it over that associated with punishments.

By the 1970s, behavior therapy had come to enjoy widespread popularity as a treatment approach to a variety of conditions that included homosexuality. Twenty-one articles published, all but two in the 1970s, report on the use of behavioral therapy - usually aversion therapy - to reduce the sexual response of gay males to other men and also frequently to increase the sexual response of gay men to female sexual stimuli.

Since the 1970s, the attention of behavioral therapists has increasingly focused on their clients' cognitive processes, and many behaviorists have begun to use cognitive-behavioral therapy as the preferred model. Aversion therapy has fallen out of favor with a majority of behaviorists and has been largely abandoned for the purpose of changing sexual orientation or behavior secondary to mounting evidence of a failure in long term efficacy.

The Addiction and Compulsive Models of Homosexuality

In his book *Homosexuality and the Politics of Truth*, Satinover (2001) compares homosexuality with alcoholism and attributes to it the following negative side-effects:

- A significantly decreased likelihood of being able to establish or preserve a successful marriage.
- A 25 to 35 year decrease in life expectancy (because of the risk of contracting HIV/AIDS).
- The risk of contracting chronic, potentially fatal, liver disease (infectious hepatitis, which increases the risk of liver cancer).
- The inevitable contraction of a fatal immune disease, including associated cancers.
- An elevated risk of developing rectal cancer, which is often fatal.
- The risk of contracting multiple bowel and other infectious diseases.
- A much elevated incidence of suicide.
- The improbability of being able to eliminate adverse affects of the condition unless the condition itself is eliminated.
- The possibility of eliminating homosexuality stands at only 50% and necessitates lengthy, often costly, and invariably very time-consuming treatment in the case of unselected sufferers (although he notes success rates of as high as almost 100% in the case of carefully selected, highly motivated individuals).

Satinover relates homosexuality to alcoholism, saying that even though its origin may be influenced by genetics, the condition is, strictly speaking, a behavioral pattern. Secondly, individuals who have this condition continue to demonstrate these patterns of behavior despite the destructive consequences of doing so. Thirdly, although some people with this condition perceive it as a problem and wish they could rid themselves of it, many others deny that they have any problem at all and violently resist all attempts to 'help' them. Fourthly, some of the people with this condition - especially those who deny it is a problem - tend to socialize almost exclusively with one another, forming a subculture (Satinover, 2001).

The last decade of the twentieth century saw the appearance of many 'transformational ministries' intended to support homosexuals in their struggle to abstain from non-heterosexual behavior through prayer, spirituality, and the application of the principles of the '12 steps of recovery' promoted by Alcoholics Anonymous. Many of these transformational ministries also incorporate principles from the reparative and conversion therapies.

Homosexuality as Disease

Despite serious political challenges from homosexual activists and their ideological allies, psychiatric consensus on homosexuality remained undisturbed until 1968 (Bayer, 1987). In 1952, when the American Psychiatric Association issued its first official listing of mental disorders, homosexuality and other sexual deviations were included among the sociopathic personality disturbances. These were deemed to be characterized by the absence of subjectively experienced distress or anxiety despite the presence of profound pathology. Explicitly acknowledging the centrality of dominant social values in defining such conditions, *DSM*-I asserted that individuals so diagnosed were " ... ill primarily in terms of society and of conformity with the prevailing cultural milieu" (Bayer, 1987).

In 1968, the second edition of the APA's *DSM* removed homosexuality from the category of sociopathic personality disturbances and listed it, together with the other sexual deviations (fetishism, pedophilia, transvestitism, exhibitionism, voyeurism, sadism and masochism) as "other non-psychotic mental disorders." Two years after the release of the second edition, the *DSM* became the central focus of the Gay Liberation movement's attack on psychiatry (Bayer, 1987).

In 1973, homosexuality was deleted from *DSM* nomenclature. This decision marked the culmination of two decades of struggle within psychiatry and in the American and Western cultures, which resulted in the shattering of the fundamental moral and professional consensus on homosexuality (Bayer, 1987).

Despite the fact that the American Psychiatric Association has established that homosexuality is not a disease *per se*, there remain those within the mental health community who view non-heterosexuality, as well as many variants within heterosexual behavior, as pathological processes amenable to psychological intervention.

Gender-identity Disorders

Although homosexuality has been removed from the APA's DSM, gender-identity disorder (GID) and childhood gender-identity disorder (CGID) remain. Gender-identity disorder is described as a strong and persistent cross-gender identification with persistent discomfort in the gender role of the assigned sex. The diagnosis of gender-identity disorder is not made

when the clinical scenario is complicated by chromosomal or physical inter-sex conditions. GID is also a separate and distinct entity from transvestitism.

Gender-identity disorder is the diagnosis for which sex change operations were developed. Retrospective and prospective data indicate an unusually high incidence of depression and suicide attempts in adult males who developed a gender-identity disorder in childhood and remained untreated, which fact is viewed as further evidence for continued inclusion in the APA's DSM.

Childhood GID is marked by cruel teasing and rejection on the part of peers towards a child who is different, as well as marked distress and severe maladjustment on the part of the child, not merely as a function of a rejecting society and peer group, but primarily as a function of the disorder itself (Rekers & Kigus, 2001).

Bailey and Zucker (1995) report that 64% to 75% of boys whose gender-identity disorder was untreated in childhood develop homosexual or bisexual orientation during adolescence while the remaining 6% to 23% develop a heterosexual orientation in adulthood. The association between GID in girls and homosexuality in adulthood is unclear (Rekers & Kilgus, 2001). These statistics further induce parents to initiate treatment early and aggressively.

There are some political activists and philosophers with a variety of social agendas - including some mental health care professionals - who vigorously question whether the gender-identity disorder warrants diagnosis, assuming that the problem lies with society, not the patient. On the other hand, the harsh reality is that without a diagnosis it becomes increasingly difficult to offer treatment, especially when it is to be subsidized by health care institutions, insurance companies, and social agencies.

For most of the twentieth century, psychological explanations for homosexuality remained tied to Freudian theory. However, as psychology and psychiatry matured and diversified so did the explanations for homosexuality, evolving from their Freudian roots into a complex tapestry of hypothetical postulations. Many contemporary clinicians have abandoned their formal training and academic grounding in psychological theory in favor of a more pragmatic view, one that:

- Acknowledges contributions from both biology and environment.

- Is willing to entertain multiple hypothetical explanations simultaneously without mutual exclusivity.
- Acknowledges the importance for theory as a framework upon which to build discussion, not the discovery of fact or assessment of blame.

Chapter 10: The Sexual Reorientation Interventions

Silverstein notes that there has always been a close fit between social norms and medical diagnosis and treatment. When Western society was struggling for a moral rationale to decriminalize and de-stigmatize homosexuality, medicine hypothesized both biological and psychological origins and offered interventions. Homosexuality, although it has traveled from being viewed as a sin to interpretation as, respectively, sickness and healthy alternative, remained illegal and was until recent years widely considered immoral throughout Western society (Silverstein, 1996). This chapter explores current and past reorientation interventions under debate.

Silverstein asserts that homosexuals suffered depression, misery, and risk of suicide because they were taught to suffer, first by society at large and then by the scientific community which, in an attempt to explain the perceived immorality of homosexual behavior, declared that homosexuality was a medical illness. Early gay, lesbian, and feminist political movements in Europe and America readily accepted the scientific formulation that became a central theme in the movement to decriminalize homosexual behavior.

Approaches in clinical psychotherapy to changing sexual orientation have almost exclusively involved efforts to change homosexual and bisexual orientations to a heterosexual orientation (Nicolosi, 1991) and dealt largely with men rather than women (Adams & Sturgis, 1977). Stein emphasizes the fact that attempts to change sexual orientation parallel the focus of anti-homosexual bias and heterosexism in American society.

The focus on the sexual reorientation of men rather than women results not only from a greater emphasis in general in the psychological literature on men, but also from the tendency in Western society for reactions towards male homosexuality to be much stronger and more virulent than those towards female homosexuality (Stein, 1996). This differential reaction is presumed to be due to the greater rigidity of gender role requirements for men - and their consequent anxiety about gender variation - and to the devaluation of women's sexuality in general (Stein, 1996).

In addition to the psychodynamic therapy, behavioral therapy, drug, hormone, and surgical interventions described by Murphy (1992), Haldeman (1994) describes a variety of religion-based conversion therapies. All of these are based on the premise that homosexuality is morally wrong, medically pathological and socially undesirable (Stein, 1996).

Psychodynamic and Psychoanalytic Interventions

Since the late nineteenth century, the psychiatric and psychologic communities have invented theories to explain the genesis of homosexual behavior. Freud (1922, 1962) suggested psychodynamic factors. Rado (1940), objecting to Freud's acceptance of bisexuality, established the phobic theory of homosexuality and gave birth to the Adaptation School of Psychoanalysis. Bieber (1962), Socarides (1978) and Hatterer (1970), who were born of this school, attempted to cure homosexuals of their orientation in the name of goodness and mercy (Silverstein, 1996). Bieber describes reconstructive psychoanalytic treatment exposing the 'irrational fears of heterosexuality', with the intention of helping the homosexual to resolve them. When the irrational fears are resolved, the patient's latent heterosexuality is able to surface (Bayer, 1987).

For Socarides (1969):

> Successful psychoanalytic therapy for homosexuals requires the uncovering of an unconscious desire to achieve masculinity through identification with the male sexual partner, understanding the pre-Oedipal fears of incorporation and engulfment by the mother and the fears of personal dissolution that attend any effort to separate from her, analysis of the Oedipal fears of incest and aggression, discovery of the role of the penis as a substitute for the mother's breast, the surfacing of the yearning for the father's love and protection, and recognition of the presence of repeatedly suppressed heterosexual interests and desires (p.32).

Once the crippling fear and revulsion of women are eliminated, the former homosexual can "function in the most meaningful relationship in life: the male-female sexual union and the affective state of love, tenderness, and joy with a partner of the opposite sex" (Socarides, 1972, p.43).

Behavioral Therapies

The behaviorist school also attempted to convert homosexuals to heterosexuality, although they formulated the etiologies of non-heterosexuality differently than did the traditional psychodynamic community. Although some of their treatments were caustic, gay liberationists have depicted the aversion therapies as 'torture' and 'punishment', even though the vast majority of the patients were voluntary participants. Three forms of aversion therapy were popular during the 1960s and 1970s. Feldman and MacCulloch (1971) used electric shock aversion therapy (different from electroconvulsive therapy), in which an uncomfortable

electric stimulus was administered to the male patient following an erotic response to photographs of nude males (Feldman, 1977). Cautela (1967) and Barlow et al (1969) popularized a procedure called 'covert sensitization', in which disgust and images of vomit were used to 'diminish' homosexual desire. The third form of aversion therapy used the drug apomorphine (McConaghy et al, 1972), which induces nausea.

Davison (1968) developed 'Playboy Therapy', in which gay men masturbated to pictures of naked women. He later rejected his early work as ineffective. Heath (1972) introduced the most bizarre form of sexual reorientation intervention by far, implanting electrodes into the pleasure centers of a gay man's brain and stimulating them while a prostitute attempted to seduce him.

Underlying psychiatry and psychology's attempts to change sexual orientation is a basic philosophical belief in the potential malleability of human behavior and sexual orientation (Silverstein, 1996). However, of all the gay men who volunteered for 'the cure', few were able to claim that their sexual orientation had changed as a result of behavioral therapies (Silverstein, 1996). Researchers frequently 'blamed' the patients themselves for not being sufficiently motivated (Silverstein, 1996). Outrage, a British support group for lesbians and gays, recently asked the Royal College of Psychiatrists (UK) to renounce aversion therapy and instruct its members to halt "the use of all therapies that attempt to cure homosexuality."

12 Step programs for Sex-Addiction

The '12 Steps' program is a popular American self-help model with strong Protestant themes traditionally used for the management of alcoholism and other addictive disorders including recreational drugs, gambling and 'sexual addictions'. A few mental health professionals, such as Satinover, find it useful to view ego-dystonic homosexuality as an addictive-compulsive behavior readily managed by using the principles of the 12 step programs. Most of the '12 Step' resources for homosexuals seeking reorientation are linked to Protestant religious groups and heavily tied to Protestant moral values about sexuality, family, and God. In addition to support group meetings, 'retreats' that resemble the rehabilitation model for chemical and substance addictions and individual counseling and pastoral care by both church members and mental health professionals are traditionally part of the package.

The American gay and lesbian political community has been extremely active in its efforts to discredit these religious based interventions as both ineffective and dangerous. Reports of 'brain-washing' and 'cults' have been bandied about, although there is little evidence to support such claims.

Surgical Interventions

The first attempt to cure homosexuality with surgery was performed by Steinach in 1917 (Schmidt, 1984). The procedure is described as the hemicastration of a homosexual male together with the transplant of testicular tissue from a heterosexual male. The belief was that the transplant of normal healthy heterosexual testicular tissue from a donor would facilitate conversion to heterosexuality and lead to successful marriage and parenting of children. Twelve men were subjected to surgery, but the experiments were a complete failure.

In 1962, Roeder introduced a new surgical technique, producing a right-sided lesion in the tuber cinereum (hypothalamic structure) of the brain of an incarcerated 51 year old homosexual pedophile. A total of 75 German prisoners or chronically institutionalized men received similar operations for the management of aberrant sexual behavior, and the procedure was promoted as an inexpensive alternative to long-term psychotherapy. There was no evidence to suggest that sexual orientation changed in any of the participants (Schmidt & Schorsch, 1981) and sex researchers in Germany demanded that their government declare a moratorium on the use of these surgical techniques (Sigusch et al, 1982). The publicity about the inhuman nature of these experiments has brought them to a halt (Reiber & Sigusch, 1979).

Hormones and Prenatal Interventions

Durner et al (1987), clear in their intent to eradicate homosexuality, advocated altering the hormonal environment of the fetus. Durner (1983) states:

> It was concluded from these data that ... it might become possible in the future - at least in some cases - to correct abnormal sex hormone levels during brain differentiation in order to prevent the development of homosexuality. However, this should be done, if at all, only if it is urgently desired by the pregnant mother (p.578).

Meyer-Bahlberg and his colleagues at the Psychiatric Institute in New York also worked toward identifying the prenatal hormone influences on sexual orientation and gender

behavior, although they rejected the use of this information to alter sexual orientation (Meyer-Bahlberg, 1977, 1979, 1984). Thus far, research has not produced any clinically useful interventions, although it is difficult to predict what the future may hold.

Childhood Gender-identity Disorder Interventions

Rekers and Kilgus (1995, 1998) report that psychotherapeutic interventions with childhood and adolescent GID produce normalization of gender-identity and reduce the future incidence of homosexual and bisexual orientation in adolescence and adulthood. According to Rekers, transsexualism and transvestism are quite difficult to treat in adulthood (2001), so early detection and intervention hold the greatest promise of normalizing gender identification and preventing the high levels of depression and suicide associated with adult transsexualism (1995).

Positive reinforcement for normal sex-typed play, normal speech patterns and gender appropriate behavior has been found to be effective in the clinic, home and school environments, particularly when parents are trained to carry out behavior-shaping programs in the child's environment and closely supervised by a child mental health professional (Rekers, 1995; Rekers & Kilgus, 1998). With emerging transvestite-like behaviors in male adolescents (where female garments are used for sexual arousal), specific psychotherapeutic and behavior therapy interventions have been found to be effective (Rekers, 1995; Zucker and Bradley, 1999).

Reparative Therapies, Conversion Therapies, and Transformational Ministries

The two methods of sexual reorientation interventions that emerged in the early 1970s and are still widely used by therapists and lay groups include *reparative therapy*, an experimental and controversial secular therapeutic technique and *transformational ministries*, consisting of various religious and spiritual practices combined with individual and group therapies based on the reparative and addiction models. The groups engaged in such interventions often report a success rate of 70% or more, while many gay, lesbian, and mental health groups estimate a conversion rate of 0%. Reparative therapy is also widely known as 'conversion therapy'.

For some, *reparative therapy* refers to a specific secular counseling technique that involves helping a gay or lesbian bond in an intimate but non-sexual relationship with an adult member of the same gender. This is believed to substitute for the bond between the client and their same-sex parent which, therapists allege, did not form properly during childhood. Others consider *reparative therapy* to include the prayer, religious conversion, one-on-one counseling, and group counseling provided by Christian *transformational ministries.*

In a book widely circulated among conservative American Christians, Moberly describes a 'reparative' therapy in which the gay client is encouraged to enter into an emotionally close, non-sexual, non-erotic relationship with another male adult. Once this has been achieved, heterosexual feelings are expected to emerge over time while homosexual feelings fade.

Gay Affirmative Therapy

With the removal of homosexuality as a 'diagnosis' from the *DSM*, the increasing political prominence of the gay and lesbian liberation movements and the birth of sex research as a scientific discipline separate from psychiatry and psychology, the early 1970s witnessed an explosion of 'gay counseling centers' throughout America.

Maylon (1982) describes gay-affirmative psychotherapy as:

> The theoretical position that regards homosexuality as a non-pathological human potential. But while the traditional goal of psychotherapy with homosexual males has been conversion (to heterosexuality), gay affirmative strategies regard fixed homoerotic predilections as sexual and affection capacities which are to be valued and facilitated (p.60).

According to Maylon,

> ... the primary goal of gay affirmative psychotherapy is to alleviate the harmful effects of internalized homophobia. Since the removal of homosexuality from the DSM, the literature on psychotherapy with gays and lesbians can be divided into three areas: 1) external stressors, 2) internal stressors, 3) psychotherapeutic technique (p.71).

External stressors include: homophobia (Herek; 1984, 1989), relationships with families (Myers, 1982; Silverstein, 1977), parenting children (Kirkpatrick, 1987; Loulan, 1986; Martin, 1989), civil and legal rights, 'coming out' (Coleman, 1982), the problems of adolescents (Hetrick & Martin, 1987; 1988), impediments to successful love relationships

(Burch, 1986; Peplau & Amaro, 1982; Silverstein, 1981), discrimination (Herek, 1984), and the AIDS epidemic (Silverstein, 1996).

Psychotherapy around the internal stressors include: internalized homophobia (Herek, 1984; Maylon, 1982; Smith 1988), affective disorders and sexual problems (Hall, 1987; Reece, 1987), identity formation (DeCecco, 1981; DeCecco & Shiveley, 1983/1984), borderline personalities (Silverstein, 1988) and merger in lesbian relationships (Burch 1986).

The third area of emphasis is on psychotherapeutic technique (Silverstein, 1996). Hencken (1982) has tried to bridge the gap between psychoanalysis and gay affirmative therapy, by suggesting that one can use psychoanalytic technique while ignoring traditional analytic beliefs about normal sexual development. Isay (1985) explores heterosexist bias in psychoanalysis and the failure to examine the special relationship between the gay son and his father. Johnsgard and Schumacher (1970) explore the use of group psychotherapy with gay men. Fensterheim (1972) applied assertiveness training techniques to gay populations and Davison (1976, 1977) explored the ethical and therapeutic concerns surrounding clinical work with gays and lesbians. This more recent literature emphasizes that the pursuit of the elusive 'cause' of homosexuality is closely related to political, social, and legal efforts to repress homosexuality (Silverstein, 1996).

Carnes (1983), Mattison (1985), and Quadland (1985) have explored the significant controversy that continues to surround 'sexual addiction' and 'sexual compulsions'. Using the paradigm of drug addiction, proponents of these approaches treat 'compulsive sexuality', consisting of such behaviors as compulsive masturbation, frequent sex, failure to be monogamous, and guilt about sexual acts, with a 12 step program like that employed by Alcoholics Anonymous (Silverstein, 1996). A similar model has been developed for sexual reorientation in the less central areas of psychological, counseling and ministerial therapies.

Outcome Studies, Case Reports and Opinions

Psychoanalysis and Psychodynamic Therapies

The early work of Stekel (1930) reports a number of complete cures through Freudian psychoanalysis, including one case that is discussed in detail. Anna Freud (1949, 1952) refers to several cases that show 'good results', including four that led to heterosexual adjustment.

Ovesey (1969) reports three cases to have continued to be successful a minimum of five years after treatment.

One of the most ambitious psychoanalytic studies of male homosexuality in the period following Rado's theoretical revision was undertaken in the 1950s by the New York Medical Society of Medical Psychoanalysts. The project involved 77 psychiatrists who contributed information on 106 homosexual and 100 heterosexual patients, with the latter serving as controls. In order to standardize the vast amount of data being collected, all participating analysts were asked to complete a questionnaire consisting of 450 items covering a full range of familial, social, diagnostic, and therapeutic issues (Bayer, 1987). The results of the study, entitled *Homosexuality,* were published in 1962 under the primary authorship of Bieber (1967), " ... although this change may be more easily accomplished by some rather than others, in our judgment a heterosexual shift is a possibility for all homosexuals who are strongly motivated to change" (p.82). Bieber concluded that analysts should direct their efforts towards helping their patients achieve heterosexuality rather than adjust to homosexuality.

Bayer finds it remarkable, given Bieber's assertions, that the data provided by *Homosexuality* tend to suggest more modest results. Of the seventy-two patients who were exclusively homosexual at the outset of treatment, 57% remained unchanged at the end of the study while 19% had become bisexual and only 19% exclusively heterosexual. By combining the data from the exclusively homosexual and the bisexual, it can be calculated that 27% had shifted to exclusive heterosexuality.

Bayer notes that:

> ... those who made the shift to heterosexuality had exhibited a willingness to embark on the long, difficult, and often frustrating course of analytic therapy. Only two of twenty-eight patients (7%) with fewer than 150 hours of treatment had become heterosexual, nine of the forty patients (23%) who had undergone between 150 and 349 hours of analysis had made the shift and eighteen of the thirty-eight patients (47%) who received more than 350 hours of treatment had made a successful transition (pp.62-63).

Wallace (1969) describes the successful case treatment of a homosexual following a relatively brief period of psychoanalysis, as does Eidelberg (1956). Utilizing a group therapy format, Birk (1974) also claims significant improvement in a number of cases. In a study of thirty homosexual college students, Whitener and Nikelly (1964) report considerable

improvement among patients who were highly motivated, had relatively healthy character structures, and had not been acting out homosexuality for a long period. Of fifteen college students, Ross and Medelsohn (1958) report that eleven showed mild to considerable improvement. Monroe and Enelow (1960) describe significant change in four of seven patients. Mayerson and Lief (1965) reported successful outcomes in a detailed study; they found that 47% of the patients were functioning heterosexually after a follow-up of a mean of four and half years. Ellis (1956) reports that eighteen of his twenty-eight male homosexual patients had 'distinct' or 'considerable' improvement in achieving satisfactory sex-love relations with women.

In 1979, Masters and Johnson claimed an impressive conversion rate of 50 to 60%, which was maintained for 5 years after treatment. These results have often been quoted by the proponents of reparative therapy, although these patients received short-term, intensive individual psychodynamic psychotherapy and behavioral modification (not aversion) by licensed clinicians. Notable for the Masters and Johnson data is that all participants were bisexual, were in a relationship with access to heterosexual contact, and in all cases behavior was the measured endpoint rather than orientation (as evidenced by fantasy, dreams, objects of erotic arousal).

Behavioral Therapy

Although Wolpe (1969) reports a spontaneous reversal of homosexuality in a client after he had left behavioral treatment several prominent authors previously in support of aversion type behavioral therapy later publicly reversed their positions. It is now generally held that aversion therapy has failed to demonstrate long-term success (results extending beyond the initial phase of aversion therapy treatment) for any of the symptoms or disorders for which it has been used (alcoholism, smoking, drinking, homosexuality).

The problem with aversion therapy is that once the negative consequences (aversive stimuli) are discontinued, behavior tends to revert to baseline in the majority of cases, particularly when the behavior to be extinguished is physically or emotionally pleasurable. The other problem with aversion therapy is tracking the impact of secondary gain. For example: if release from the psychiatric hospital or a return to active duty military status is

dependent in part on one's success with aversion therapy, it becomes considerably more difficult to accurately assess the treatment success rates, a problem that has plagued a number of behavioral studies.

Reparative Therapies and Transformational Ministries

Pattison and Pattison (1980) describe eleven men who overcame homosexuality through spirituality based conversion. In a very detailed analysis of therapeutic results, van den Aardweg (1986) divided a hundred and one homosexual clients into four categories: Radical Change, Satisfactory Change, Improved, No Change. Among those who continued more than several months in treatment, 65% are reported to have achieved results in the categories 'Radical Change' or 'Satisfactory Change'.

Spitzer, a Professor of Psychiatry at Columbia University, conducted a study of 143 homosexual men and 57 homosexual women who had undergone reparative or conversion therapies and reported his findings, 2001 that they had become 'straight,' at a meeting of the American Psychiatric Association on May 9th, 2001. Following forty-five minute interviews with each subject, he concluded that 66% of the males and 44% of the females had arrived at 'good heterosexual functioning'. Critics complain that the subjects were carefully selected and referred for this study by a group that strongly promotes reparative therapy, when a random sample of past participants in reparative therapy would have been preferable. Also of interest is the fact that all the subjects described themselves as being bisexual at the time of the study. It is unknown what percentage identified as bisexual prior to the onset of reparative therapy.

A new North American study is underway by Schroeder and Shidlo to determine the experiences of people who have been treated either by Ex-Gay ministries or by individual reparative therapists. It is sponsored by the National Gay and Lesbian Task Force, and funded by the H. van Ameringen Foundation. By late 1997, they were half way towards their goal of 200 subjects. Shidlo reports that he had yet to find a single cure as result of reparative therapy. Two subjects had reported a cure but later admitted to having decided to become celibate. The study specifically looks for harmful or negative effects caused by participation in reparative therapy. Considering who the sponsor is, it is reasonable to assume that few

conservative Christians have participated in the Schoeder-Shidlo study. The researchers announce their bias upfront by stating: "You can be of help in the long process of getting the message out that these conversion therapies don't work and do the opposite of healing by informing your communities of our search for participants to be interviewed. Help us document the damage" (Schoeder & Shilo, 2001, p.3).

Drescher (2001), an American psychoanalyst who works extensively with gays, commented:

> My own clinical experience with gay men who failed to change in reparative therapy is that they suffered damage to their self-esteem, experienced resultant anxiety and depression, and often felt a deep mistrust of mental health professionals. This mistrust and shame may explain why no good follow-up studies of these individuals exist (p.1).

Predictors for Successful Intervention

Practitioners of sexual reorientation interventions have identified a variety of features that predispose subjects to sustained success with efforts to change sexual behavior and sexual orientation. These are: religiosity, religious motivation, youth, limited homosexual experience (number of partners, duration of behavior), bisexual behavior/orientation (experience and fantasies), occupational and social stability, and commitment (as expressed by persistence with an intervention treatment plan). One of the strongest predictors in the Bieber study of psychoanalysis and sexual reorientation was the number of visits with the psychoanalyst. Reparative therapists such as Nicolosi and van den Aardweg view gender inferiority and disordered paternal attachment as the best predictors for success, in large part because these are the issues that their interventions target. Addictionologists and spiritualists emphasize a life-long commitment to treatment and relapse prevention as the essential ingredient.

Complicating the predictors for success is, of course, the question of how success is defined. Gay and lesbian political activists define success as heterosexual orientation and behavior with the absence of any evidence of homosexual orientation (arousal, eroticism, fantasies) and then report that there are no scientific data supporting claims for any intervention's success. Christian conservatives and sexual reorientation practitioners define success in a variety of terms: ego-syntonic abstinence from same gender sexual relations (through celibacy or heterosexual relations), ego-syntonic opposite gender sexual relations, or

diminished homosexual orientation and enhanced heterosexual orientation. Gay and lesbian political activists and practitioners of gay affirming therapies almost universally define success in terms of orientation while Christian conservatives and reorientation practitioners emphasize sexual behavior. It is clear, therefore, that the manner in which success is defined is the primary predictor of outcome for studies on treatment efficacy.

Chapter 11: Statements by Professional Associations

This chapter reviews the input from professional groups from within the health care system and places them in a cultural and historical perspective. None of these statements have been developed easily with unanimous consensus. The behind the scenes discussions from within the various professional groups in many ways mimics the public debate. A historical review highlights the frailty of professional consensus and the impact of public opinion and social pressure on organized health care.

An American Psychiatric Association fact sheet prepared for educators states in part:

> The most important fact about 'reparative therapy', also sometimes known as 'conversion therapy', is that it is based on an understanding of homosexuality that has been rejected by all the major health and mental health professions. The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the National Association of School Psychologists, and the National Association of Social Workers, together representing more than 477,000 health and mental health professionals, have all taken the position that homosexuality is not a mental disorder and thus there is no need for a 'cure' (APA, 2001) ... health and mental health professional organizations do not support efforts to change young people's sexual orientation through 'reparative therapy' and have raised serious concerns about its potential to do harm (2001, p.1).

In 1993, the American Academy of Pediatrics published a policy statement entitled *Homosexuality and Adolescence*. It was critical of any form of sexual reorientation intervention, commenting:

- "Some adolescents are uncertain about their sexual orientation. For them, a 'counseling or psychotherapeutic initiative' aimed at clarification might be useful. Therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation."
- "The psychosocial problems of gay and lesbian adolescents are primarily the result of social stigma, hostility, hatred and isolation."
- The statement mentioned that about 30% of "a surveyed group of gay and bisexual males have attempted suicide at least once."

In 1994, the American Psychiatric Association released a fact sheet that stated:

> There is no published scientific evidence supporting the efficacy of 'reparative therapy' as a treatment to change one's sexual orientation. It is not described in the scientific literature, nor is it mentioned in the APA's latest comprehensive Task Force Report, Treatments of Psychiatric Disorders (1989, p.1).

There are a few reports in the literature of efforts to use psychotherapeutic and counseling techniques to treat people who are troubled by their homosexuality and desire to become heterosexual. Results have not been conclusive, however, and nor have they been replicated. There is no evidence to suggest that any treatment can change a homosexual's deep-seated sexual feelings for others of the same sex (APA, 1994).

The American Psychological Association has published a brochure entitled *Answers to Your Questions About Sexual Orientation and Homosexuality* (2001). It contains a section called: "Can Therapy Change Sexual Orientation?" which reads:

> No. Even though homosexual orientation is not a mental illness and there is no scientific reason to attempt conversion of lesbians or gays to heterosexual orientation, some individuals seek to change their own sexual orientation or that of another individual (for example, parents seeking therapy for their child). Some therapists who undertake this kind of therapy report that they have changed their client's sexual orientation (from homosexual to heterosexual) in treatment. Close scrutiny of their reports indicates several factors that cast doubt: many of the claims come from organizations with an ideological perspective on sexual orientation, rather than from mental health researchers; the treatments and their outcomes are poorly documented; and the length of time that clients are followed up after the treatment is too short (p.3).

In 1990, the American Psychological Association stated that:

> ... scientific evidence does not demonstrate that conversion therapy works and that it can do more harm than good. Changing sexual orientation is not simply a matter of changing one's sexual behavior. It would require altering one's emotional, romantic, and sexual feelings and completely restructuring one's concept of self and social identity. Although some mental health providers do attempt sexual orientation conversion, others question the ethics of trying to alter a trait that is not a disorder and that is extremely important to an individual's identity through therapy (p.2).

A 1994 resolution which would have branded therapists engaged in reparative therapy as following unethical practice was defeated by the membership of the American Psychiatric Association. A similar resolution was defeated by the American Psychological Association in 1995. However, the latter overwhelmingly passed a resolution on August 14, 1997, which stopped just short of calling this form of therapy unethical. Haldeman, President of the APA's Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues, helped to write the resolution, saying:

> In the past 10 years, Christian fundamentalists have enlisted a coalition of old-style psychologists, psychiatrists and social workers who have become very visible in this country and internationally, and who have as a mission to 'help' homosexuals get rid of the sexual orientation. Our aim is not to try to stop them per se or interfere with anyone's right to practice [therapy] but we want to expose the social context that creates this market (1994, p.1).

APA officials are concerned that some who enter therapy do so because of the coercion of their families, employers, church members, etc. The APA resolution requires that the therapist obtain 'informed consent' from the client (2001). This is to include:

1. A full discussion of the client's potential for happiness as a homosexual,
2. communication to the client that there is no sound scientific evidence that the therapy works,
3. raising the possibility that therapy may exacerbate the client's problems, and
4. an analysis of the client's true motivation for wanting to change.

A spokesperson for the National Association for Research and Therapy of Homosexuality (NARTH), Socarides, commented on the resolution, saying:

> Homosexuality is a psychological and psychiatric disorder, there is no question about it. It is a purple menace that is threatening the proper design of gender distinctions in society (1999, p.2).

NARTH complained that the resolution infringed on the rights of therapists, that it was passed without due process and that an open hearing should have been conducted in which NARTH and other organizations could have participated. They would like the APA to attempt to correct what they feel is the "very widely disseminated, popular misconception that homosexuality is genetic." The resolutions received condemnation from Evangelical Christian groups and support from gay and lesbian civil rights groups.

In 1996, the National Association of Social Workers (NASW) adopted a policy statement on lesbian, gay and bisexual issues. It states, in part:

> *Social stigmatization of lesbian, gay, and bisexual people is widespread and is a primary motivating factor in leading some people to seek sexual orientation changes. Sexual orientation conversion therapies assume that homosexual orientation is pathological and freely chosen. No data demonstrate that reparative or conversion therapies are effective, and in fact they may be harmful. NASW believes social workers have the responsibility to clients to explain the prevailing knowledge concerning sexual orientation and the lack of data reporting positive outcomes with reparative therapy. NASW discourages social workers from providing treatments designed to change sexual orientation or from referring to practitioners or programs that claim to do so (NASW, 1997, p.3).*

On January 9th, 1997, the *Wall Street Journal* published an editorial in support of reparative therapy, called: "Don't forsake homosexuals who want help." A flood of highly critical letters to the editor resulted, from psychiatrists, sociologists, lesbigay associations, and individuals (WSJ, 1997).

The American Psychological Association overwhelmingly passed a resolution on Aug 14th 1997, directed against reparative therapy and affirming a number of basic principles when accepting homosexual and bisexual clients. These include:

- That homosexuality is not a mental disorder.
- That psychologists do not "knowingly participate in or condone discriminatory practices with lesbian, gay and bisexual clients."
- That "psychologists respect the rights of individuals, including lesbian, gay and bisexual clients, to privacy, confidentiality, self-determination and autonomy."
- That "psychologists obtain appropriate informed consent to therapy in their work with lesbian, gay and bisexual clients."

Their resolution concluded by saying that:

> *... the American Psychological Association opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation and supports the dissemination of accurate information about sexual orientation, and mental health, and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about sexual orientation (APA, 1997, p.3).*

By way of contrast, the Chinese Psychiatric Association still classified homosexuality as a mental disorder in 1997 (CPA, 1997). Most professional therapists in China regard homosexual orientation as a curable illness, and electric shock treatments are sometimes used in a futile attempt to convert non-heterosexuals (CPA, 1997).

On December 4th 1998, the American Psychiatric Association rejected reparative therapy as ineffective and potentially destructive (Katz, 1998). Their Board of Trustees unanimously adopted a position statement opposing reparative therapy. APA President Rodrigo Munoz commented:

> It is fitting that this position opposing reparative therapy is adopted on the 25th anniversary of the removal of homosexuality as a mental disorder from the DSM. There is no scientific evidence that reparative or conversion therapy is effective in changing a person's sexual orientation. There is, however, evidence that this type of therapy can be destructive (1998, p.3).

The APA statement said:

- "The potential risks of 'reparative therapy' are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient."
- "Many patients who have undergone 'reparative therapy' relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction."
- "The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed."
- "Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as 'reparative' or 'conversion' therapy which is based upon the assumption that homosexuality *per se* is a mental disorder or based upon a prior assumption that the patient should change his/her homosexual orientation. The American Psychiatric Association recognizes that in the course of ongoing psychiatric treatment, there may be appropriate indications for attempting to change sexual behaviors" (APA, 1998, p.4).

On January 15th of 1999, the American Psychiatric Associations Board of Trustees:

> ... endorsed a position stating at its December meeting that it opposes therapeutic techniques some psychiatrists and mental health professionals claim can shift an individual's sexual orientation from homosexual to heterosexual. The Board acknowledges that there is no evidence that these so-called 'reparative therapies' have any efficacy in converting someone from one sexual orientation to another (p.2).

During the 1999 Annual Press Release, at its World Conference, the American Counseling Association adopted a position in opposition to the promotion of 'reparative therapy' as a 'cure' for homosexuals.

The Board of Directors of the National Association of Social Workers (NASW) adopted a statement on therapy designed to change a person's sexual orientation, saying, in part:

> The increase in media campaigns, often coupled with coercive messages from family and community members, has created an environment in which lesbians and gay men often are pressured to seek reparative or conversion therapies, which cannot and will not change sexual orientation (1997, p.2).

Aligned with the American Psychological Association's 1997 position, the National Caucus for Lesbians, Gays, and Bisexuals: " ... believes that such treatments potentially can lead to severe emotional damage."

The National Association for Research and Therapy of Homosexuality (NARTH) is the only professional group that considers homosexuality to be a 'sexuality disorder'. Below is listed a series of beliefs subscribed to by NARTH, some of which are taken from the

association's Statement of Policy, while others are derived from a speech given by NARTH's founder, Dr. Nicolosi to a One-By-One meeting on June 26th, 2000 (NARTH, 2001).

- Homosexuality is probably the most misunderstood 'sexual disorder'.
- Effective scientific study of homosexuality has been eroded by the gay and lesbian political movement.
- Human sexuality researchers have been intimidated into silence by a conspiracy.
- "Social-Activist groups ... have portrayed sexual deviancy as a normal way of life."
- "There is no such thing as a homosexual person. We are all heterosexuals. Homosexuality is a description of a condition. It is not a description of the intrinsic nature of the person."
- Homosexuality "works against society's essential male-female design and family unit."
- Homosexuality is caused by incompetent parenting and/or child sexual abuse.
- "The male homosexual is basically someone who did not develop a strong sense of masculine identity and he is trying to fulfill that sense of masculine deficit by connecting with a man. But the only way he knows how to do it is sexually. What feels right and natural is the sex drive that is being displaced onto a person of the same sex for emotional needs."
- Homosexuality is often caused by early sexual abuse.
- Homosexuality is preventable in childhood and treatable in adulthood.
- Most gays and lesbians can successfully convert to heterosexuality through reparative therapy (p.3).

All of the statements from bodies representing organized medicine are political, as evidenced by the many strong assertions lacking supporting data, or an exploration of the alternative views. When opinions are represented as fact, the prudent patient and clinician should suspect underlying motives.

Section IV: Queer Philosophy

The last four decades have seen the birth and evolution of philosophical thought and a growing literature by non-heterosexuals on the subject of non-heterosexuality. The lesbigay and queer communities view themselves (quite rightly) as de facto stakeholders in any ethical discussion on sexual reorientation interventions. Queer philosophy brings to social and political thought a unique language and value system with which to wage the debate. This section explores these concepts from both historical and contemporary perspectives.

Chapter 12: Identity Evolution and the Historical Homosexual

Sexual identity and, often, gender identity are at the core of requests for sexual reorientation. The philosophical and clinical formulations on identity acquisition, maintenance, and fluidity are a reoccurring theme for the debate on sexual reorientation. This chapter explores past and current philosophical and clinical theory.

Carroll believes that in order to better understand homosexual identity development, one must question the origins of notions such as the concept of a relationship between gender, patriarchy, and desire as naturally determined. Historically, this has been assumed to be a 'natural' reflection of our evolutionary heritage (Carroll, 1996). Anthropologists such as Levi-Strauss (1969) attempted to place gender division, organized heterosexuality, and the incest taboo at the crossroads of nature and culture. Thus, as Goldberg observed (1995), 'hetero-normality' assumes a foundational position. Many feminist and queer scholars (Gayle Rubin, Luce Irigaray, Monig Wittig, Judith Butler, Gerda Lerner, Kathleen Gough) have sought to pull apart this conflated foundation of repressed desire, gender, and kinship through enforced heterosexuality as the *sine qua non* of culture. In order to argue that homosexuality results from a particular crisis in patriarchy at a specific point in the past, rather than from natural causes, there is a compelling need to dismantle the history of heterosexuality (Carroll, 1996). Carroll emphasizes that in this retelling, the drive to reproduce patriarchal kinship bonds is that which organizes the socially acceptable (and unacceptable) categories of desire, not some fundamental essence, genetic encoding or psychological trauma.

Evolution and Primates

Leibowitz (1975), a feminist anthropologist, offers an interesting revisionist account of the evolution of sex roles. It has been widely assumed that sex roles evolved from the dimorphism found in upper primates. As Leibowitz (1975) put it:

> The tasks and roles assigned to men and women in our own cultural tradition were assumed to be correlated highly with anatomically based aptitudes. It is still a common belief that anatomy is destiny (p. 20).

Historically, anthropologists - almost exclusively white males, as Leibowitz points out - scrutinized primate behavior in an attempt to determine the precursors of ancient social-role differences. Their conclusions were then formulated as a justification of current sexual

practices. Through her work with a variety of primates, including those whose behavior does not resemble current human traits, Leibowitz comes to a very different conclusion:

> The sex role adaptation of the sexual dimorphic nonhuman primate species do not in fact conform to the models used in current explanations of how and why dimorphism developed among humans. In fact, sexual dimorphism cannot easily be equated with sex-role patterns. However, dimorphic primate species do have one thing in common: they all live under environmental conditions that encourage the male to range more widely than females (p. 24).

It is the call for some male primates to become long-range hunters that results in marked dimorphism. However, this does not necessarily result in male dominance or increased access to females. Leibowitz effectively contrasts gibbons, who pair for life, but who are not sexually dimorphic (they are of equal size with no special male dominance) to gorillas (who have dominant leaders who protect the group of females). She notes that, among gorillas, the dominant male has no special sexual prerogatives or preemptive rights over food. Their dominance offers protection to the group, but does not necessarily award the male increased individual rights over any particular female. Leibowitz notes this as an important unhinging of the theory of the 'natural' origins of male dominance over the reproductive rights of women and kinship systems.

Family Institution

In her exploration of the origin of the family, Gough (1975) suggests that it was this 'dominance' that eventually transmuted into 'fatherliness'. She also notes that the role, rather than developing as a genetic response to fathering a child, is largely a social role for the good of the tribe. This bond of social fatherhood is recognized among people who do not know about the male role in procreation, or where, for various reasons, it is not clear who the physiological father of a particular infant is (Gough, 1975).

Gough suggests that in the proto-human family, women still had sexual autonomy even though they were non-dominant, and bore the responsibility for rearing children. However, with increased levels of organization (the early use of fire, cooking, language, etc.), rules that lasted beyond a single generation developed and the sexual ordering of kinship began. Male dominance became the male domination of women (Gough 1975):

> Rules banning sex relations among close kinfolk must have come very early. Precisely how or why they developed is unknown, but they had at least two useful

> functions. They helped to preserve order in the family as a cooperative unit, by outlawing competition for mates. They also created bonds between families, or even between separate bands, and so provided a basis for wider cooperation in the struggle for livelihood and the expansion of knowledge (p.61).

In short, men took control of women's ability to reproduce the existing social system. By establishing a taboo on close kin sexual relations, men could organize larger and larger social systems (Carroll, 1996). However, Gough emphasizes that social roles were fairly egalitarian in the early hunting tribes. Everything was communally owned; women were as essential and often as important as men. Carroll emphasizes that, in order to survive, any small human group would recreate gender roles. In many primitive societies, the consistency of gender roles with biological sex was not ubiquitous. Occasionally, a biological male would choose to live as a woman (the Berdache of North American Indians, discussed above, being the obvious example) or vice versa. However, individuals were not allowed to demonstrate characteristics of both gender roles (Gough, 1975).

Decades of cross-cultural studies have shown that gender roles can vary radically from one group to another (Carroll, 1996). According to Leibowitz:

> ... knitting, weaving, and cooking sometimes fall into the male province, while such things as pearl diving, canoe handling and house building turn out to be women's work in some settings (p.20).

She notes, however, that in most instances men were responsible for defense and long-range hunting (when applicable) and women were generally responsible for child-rearing (Leibowitz, 1975).

On the other hand, in her groundbreaking essay, *The Traffic in Women,* Rubin (1975) stresses the repression inherent even in this early, egalitarian setting:

> Far from being an expression of natural differences, exclusive gender identity is the suppression of natural similarities. The division of the sexes has the effect of repressing some of the personality characteristics of virtually everyone, men and women (p.180).

Thus, according to Carroll, the early kinship scheme operated under several constraints, such as enforced gender roles and males' discretionary access to females. Larger systems of organization such as the state, a product of male domination and competition, began to exploit this fundamentally uneven distribution of power. Lerner (1986) specifically states that the domination of women by men, together with a Western form of consciousness stressing

dialectical thinking, is the prototypical model for *all* domination: social, economic and political.

Other feminist writers such as Irigaray (1985) and Wittig (1992) see women as autonomous beings completely disappearing into the fantasy of a world increasingly dominated by men. Women become simply the means of replicating a masculine order, while a heterosexual male of lower rank is increasingly likely to be used as a tool allowing the development of higher order male homo-social bonds. An interesting example is found in *Sowing the Body* (Dubois, 1982), where she traces the appropriation of the female body as 'metaphor' within male philosophical texts such as the Greek texts by Plato and others. Female creative powers become reworked as the creative powers of male intellectual prowess. In this way, the male was seen to metaphorically contain both woman and man. Hence, women were conceived of as defective, lesser men (Dubois, 1982).

At this point, it seems wise to step back and explore this view from two different vantage points. A more benign view of kinship and its functions is taken by anthropologists such as Gough and Geertz, who focus on the vast differences in exactly what constitutes different genders in kinship structures, marriage between cousins, brothers and sisters, etc., with respect to the political status of women. The other is that taken by Rubin, who stresses the inherently repressive nature of *any* kinship structure and the unequal power unilaterally conferred on women through such a system. However, Carroll considers this tendency towards universalization to be a product of modern culture itself and therefore open to the criticisms of modernism as outlined by Nietzsche. According to Carroll, this view ultimately reduces a very complex field that is more accurately understood by studying a complex matrix of power relationships that include class, race, age, etc., rather than by concentrating on the influence of laws surrounding the issue of incest. According to Foucault:

> There is no single, all-encompassing strategy, valid for all of society and uniformly bearing on all the manifestations of sex. The idea that there have been repeated attempts to reduce all of sex to its reproductive function, its heterosexual and adult form, and its matrimonial legitimacy fails to take into account the manifold objectives aimed for, the manifold means employed in the different sexual politics concerned with the two sexes, the different age groups and social classes (Goldberg, 1995, p. 392).

Rubin (1984) shirks this issue in an essay called *Thinking Sex,* where she separates the way in which kinship structures legislate gender roles, economic divisions, and political power

from the actual creation of sexualities. Compulsive heterosexuality is seen by Rubin first and foremost as a social institution – not necessarily one based on sexual desire. According to Carroll, this opens the door for the reworking of the inequalities of the gender system on a political level, while not inhibiting the wide-ranging, personal reworking of the gender system, thereby avoiding the feminist trap of outlawing certain systems of desire (sadomasochism, pornography, etc.), which become *de facto* replications of cultural violence against women (and men). According to Dubois (1988):

> Our paradoxical enterprise is to be both within and outside the sex/gender system, to see the ways in which it enables our being, but to call to the foreground its bias, its history (p.9).

According to Carroll:

> ... a closer look at male dominance shows just how tentative and provisional such dominance, in fact, really was. Males were usually left with their mothers for lengthy periods that resulted in a primary identification with mother that could be a threat to the sexual division of labor as codified within the prevailing gender system. Highly formalized systems of initiation (which often included scarring and other types of physical transformation) and formalized homosexual rituals cemented homo-social bonds in order to ensure that a boy was firmly on the road to a gendered manhood (p.198).

In his lengthy opus *The Construction of Homosexuality*, Greenburg (1988) outlines three major types of homosexual organization in kinship societies: trans-generational (in which the partners are of different ages), trans-genderal (the partners are of the same sex but different genders), and egalitarian (the partners are socially similar). Although Greenberg hesitates in drawing any generalizations from the various ways in which different tribes organize homosexual relations, he does offer:

> Homosexual relations are found, then, when they are most needed to solidify male power against challenges from women. They function to reproduce male-dominated gender relations where they are shaky (p.35).

According to Greenberg, as male dominance continued to expand during the rise of archaic civilizations, class divisions, and the rise of market driven economies, male homosexual relationships expanded to include more specialized types, such as a male warrior class structured through homosexual 'lover' relations, and an emerging group of lower class male prostitutes. Again, it is essential to note that these reflect social positions that may or may not have been concurrent with individual sexual desire. As Greenberg says:

> Class structured homosexuality appears with the dawn of economic stratification. Here the two partners are drawn from different economic strata or classes, the wealthier partner purchasing or commanding the sexual services of the poorer. The partners may differ in age, gender, or preference for particular types of contact, but these differences do not define the relationship. What does is the preference of the wealthier partner. Thus Captain Bligh, visiting Tahiti in the late 18th century, observed a chief sucking the penis of his attendant. By the usual conventions linking rank and sex role, this transaction should not have occurred. The attendant should have been sucking the chief. However, the chief occupied a social position that enabled him to gratify his personal preferences irrespective of conventions about homosexual roles. In societies where social relations are commercialized, wealth bestows sexual power (p.117).

Carroll notes that:

> ... growing political power created increased sexual exploitation of those with lesser power, thereby rendering the desire of the lesser partner a moot point. It had no social significance and so it did not exist. Instead, the desire of those in power was often free to range across sexes, genders, and ages (p.207).

According to Carroll, Western tradition was formed when a group of Northern Doric invaders overtook Southern Greece, bringing with them with a male dominated, patriarchal religion and - more importantly - bronze-age weapons. They quickly subsumed the older matriarchal organizations and religions and created their own complex homosexual organizations.

The myths of proto-ancient Greek culture provide an interesting insight into the kinship based homosexual organization of the time (Carroll, 1996). Sergent (1984) traces several classical myths, such as the myths of Narcissus and Hyacinth, back to their roots as stories of initiation. In particular, he outlines the typical initiation pattern for young men in proto-Greek culture:

> ... an abduction of a young man by a male suitor was followed by a month hunting in the bush (where it was presupposed that the suitor had a sexual relationship with the boy and initiated him into the ways of men). At the end of the month, the boy, now man, was restored to his family with specific gifts (an animal to sacrifice, a cup to make libations, and a sword with which to fight) that would enable him to participate in the community as a male adult. Thereafter, the boy and his suitor maintained a special relationship that lasted throughout adulthood, including the responsibility of the suitor to find the boy a suitable wife (p.102).

The importance of an older male in the role of initiator of a younger male is common in many cultures (Greenberg, 1988). Carroll notes that this practice seems at least foreign, if not suspect, in our own culture. Despite this, the story of the boy who must die to become a man can still be seen throughout Western literature and is often intertwined with ideas of homosexuality and narcissism. Paglia (1990) highlights works in the Western canon retelling this (e.g. Melville's *Billy Budd*, James Purdy's *Malcolm*, or H.H. Monro's *Bassington*) as well as those which tell the story of the abomination such a boy becomes when he lives past his time (e.g. Oscar Wilde's *Dorian Gray*). All of these works embody a lively homoerotic undercurrent. Carroll notes that Western writers repeatedly capture the inability of Western males to access this erotic connection, resulting in violence instead of initiation.

Carroll summarizes:

> Thus, society institutionalized cross-generational homosexual bonds as a way of stabilizing an exceedingly competitive male culture. However, such competition could also lead to troubles when sex was involved. Hence, the exact nature of the sexual relationship became increasingly circumscribed in order to reflect (and protect) the unequal nature of these cross-generational patterns. In addition, egalitarian homosexuality became ever more asexual as a society transformed itself from the smaller scale organization of the tribe to that of the state (p.206).

In his pioneering work, *Greek Homosexuality*, Dover (1978) outlines a classical Greek society in which the older initiatory structures were still in place and successfully bore a homoerotic connection. However, such relationships were under vastly increased scrutiny as social relationships expanded from those of a kinship society to those of a state society. Dover explicated the courtly and highly ritualized relationship in classical Athens between the 'eratastes' (the older lover) and his 'eronmenos' (the younger beloved). He stresses (Dover, 1978):

> ... the highly ritualized nature of the relationship as well as its ambiguity. For example, the younger boy was not supposed to enjoy his seduction, but to remain chaste and aloof. However, not to be wooed and won would bring dishonor to the young, noble Greek. The older lover was often laid prostrate (shedding tears, and demonstrating loss of appetite and other forms of stereotypical 'feminine' behavior) in this highly romanticized game involving an uncaring youth (p.362).

Dover emphasizes how delicate the situation could be when playing with the honor of freeborn, upper class Athenians, who were, or shortly would be, leaders of the aristocracy.

The institutionalized use of homosexual relations was an integral part of maintaining cohesion within an extremely competitive male oligarchy. As Lacquer points out, intense male friendships, *philia* – friendship, based upon *arête* – virtue, became the ethical base for a philosophy of 'the good life' and the connection between the individual and the social, between equality (of true friends) and justice (equality on a societal level). Homosexual relations, however, could also be a threat to the existing order as they allowed two men with access to power to form liaisons with revolutionary potential (Carroll, 1996). The cautionary tale of Harmodius and Aristogeiton, two lovers who killed a fifth century tyrant, became an inspiration to the oppressed in the Greek world (Bowder, 1982). According to Carroll, homosexual relations always carried an ambivalent relationship to the state. The notion of the 'ideal' friend as first articulated by Plato and subsequently Aristotle in his *Nichomachean Ethics* eventually became a rich template for idealized homosexual relations (Carroll, 1996).[2]

In ancient Greece, however, such a template was rarely coexistent with sexual desire (Carroll, 1996). Winkler (1990) emphasizes how the range of desire for a well born Athenian male (as long as one did not act passively with an inferior) was not restricted to gender but was free to range across gender lines as well as across class divisions. According to Winkler:

> Class organized sexual behavior even more than gender. The sexual act, instead of being a private one, was a social enactment of social roles based upon class distinctions. In short, a typical upper class man could have several types of sexual partners: slaves (of either sex), young boys, hetairas (female courtesans), depending upon the constraints of duty (to sire a family, to initiate a boy, etc.), availability of partners, and the whims of fancy and taste. A strictly maintained sexual orientation (of either variety) was looked upon as a nonsensical impracticality, if not an unhealthy obsession (p.403).

According to Lacquer:

> ... the ancient Greeks' hierarchical relationship of freeborn Athenian males to boys, to women, and then slaves reflected a larger cosmic order in which the adult male was seen as the pinnacle of creation. The male form was the standard; the boy and woman merely derivative (p.10).

For Lacquer:

> ... there were not two distinct sexes for the ancients. There was just one, which was modeled upon the perfect male. The woman was not seen as a distinct biological entity, but as a poor reflection of the more perfect male counterpart.

[2] The theme of the dangerous homosexual re-emerges throughout the Renaissance.

> Anatomy simply demonstrated the larger cosmic truths of patriarchy, as reflected in traditional gender roles, which were patent to the Greeks. The truth of gender roles and the domination of the male over the female came first, followed by biology. To be a man or a woman was to hold a social rank, a place in society, to assume a cultural role, not to be organically one or the other of two incommensurable sexes. Sex before the seventeenth century, in other words, was still a sociological and not an ontological category (p. 8).

Surprisingly, this ancient view has been corroborated by current research into gender acquisition (Carroll, 1996). It has been shown that young children first acquire notions of gender as a social form (e.g. Johnny is a little boy because he holds a football; Mary is a little girl because she wears a pink ribbon), and later as a physical form (e.g. Johnny is a little boy because he has a penis; Mary is a little girl because she has a vagina) (Fagot & Leinback, 1993).

In many ways, all relations in this economy of one sex were homosexual. The important difference was not the partner's sex, but "the difference in status between partners and precisely what was done to whom" (Fagot & Leinback, 1993). In this way, according to Halperin: " ... 'boy or woman' appears with perfect nonchalance in an erotic context, as if the two were functionally interchangeable (p.23)."

This is not to say that preference did not exist and that such preference could not be life long. As Carroll notes, such preference was generally seen as exactly that: a preference, not a strict orientation preordained from an early age. Halperin and his colleagues Winkler and Zeitlin suggest that the very idea of sexuality as an organized field was a foreign notion to the Greeks. Instead, as Hocquenghem suggests, sexuality was diffused throughout the public domain, within rituals, religious festivals, and household iconography and management. The idea of a 'sexual orientation' as a separate part of someone's identity around which a core self would be developed (a sense of 'me', 'not me') is very foreign to the Greek perception (Carroll, 1996). In this sense, Carroll notes that:

> ... there were men enacting homosexual acts, but no 'homosexuals' in ancient Greece. It is also important to note that the Greek sense of volition was very different from our modern sense of responsibility. Erotic desire came from outside, from the gods. Love was a madness, albeit a delightful one, that was visited upon the individual. Hence, the Greek sense of accountability for erotic acts was very different from our modern one; the gods took not only the blame, but also the guilt away from a transgression (p.202).

Carroll (1996) finds it useful to trace the trajectory of a young man's sexual experience in this world:

> As an infant and toddler, he was almost exclusively within the world of women. He was completely in his mother's charge. Men seldom penetrated into this domain. Greek women were cloistered within the house and seldom ventured forth into public. The marketplace was the natural home of the man; the house belonged to the woman. At around age five or six, a child from a family of means was put under the care of a male teacher, a pedagogue, usually a slave. This would last up until just before puberty. The pedagogue would lead the boy back and forth between classes and the gymnasium and introduce him to the rudiments of male public life. At around age 13 or 14, just prior to puberty, the boy would be taken up by an older male admirer; an unmarried male in his mid-twenties. This intense relationship would bring the boy out of the family and fully into the world of men. The boy would be involved gradually in the socializing of men: symposiums, drinking parties, hunting, etc. The older lover would act as a guide, confidant, political mentor, and lover. This relationship would last until the older lover was married (usually around age 33) or the youth no longer was physically 'youthful' (a full beard was considered a sign of manhood, which usually happened around age 18 or 19). To pursue a homosexual relationship beyond this point was considered unwise, although doubtless it was frequently done. Soon thereafter, the youth would now become the pursuer and reenact the entire process with a younger youth. The senior partner went on to marriage. He continued his relationship with his younger companion and helped to secure for him an advantageous marital match (p.104).

Winkler emphasizes that such a social arrangement served several purposes besides reenacting the patriarchal imperative:

> Puberty became a guide process of initiation by an older and wiser hand, both into the ways of men, and into the pleasures of female courtesans, paid professionals who were skilled in the erotic arts as well as often politically very savvy. Courtship and marriage with the highborn Athenian girl were still many years off. Also Athenian society saw women of marriageable status, who were secluded until marriage, more as 'property' than as fit beings for social and intellectual intercourse. Hence, they were seldom in the public eye and not available for social interaction for men in their 20s. The romantic arrangement between erastes and eromenos filled a gap before marriage, and even after. The typical age of a young bride was 13. She often had very little in common with her new husband of 33. It was expected that marital intimacy would grow in later years as the wife matured. This also ensured that in the man's old age, his wife would still be young enough to care for him adequately. (p.67)

As Trumbach points out, such non-egalitarian organization of sexual behavior is prototypic for many cultures. Echoes of its presence in Western sexual history can still be

found in modern gay culture (e.g. the cross class, cross generational nature of many European gay relationships) (Trumbach, 1989). According to Carroll (1996):

> ... it is important to note that any cultural history of homosexuality must acknowledge that as new forms of sexual organization arise, they seldom totally supplant the preexisting form. Rather, the new form overlays and mingles with, as well as co-opting, the previous form, which often will run concurrent with a competing new form (p.202).

Carroll (1996) stresses that it is important:

> ... to emphasize how the Greek scenario of male initiation into political society, was in actuality, an extremely limited phenomenon restricted to a small upper class of free born, aristocratic men. The rest of men and women living in Greece had no such prerogatives. It cannot be stressed enough how the borders of desire (and of self) were reflected though class and race, as well as gender. To the older man, a young boy's desire was simply irrelevant, as was a girl's. For the slave, it could be said not to exist. Slaves had no notion of 'individual rights' or some interior 'essence' that was inviolate; all that would come later (p.203).

Halperin (1990b) has noted that the sexual system of classical Athens, which defined the scope of sexual object choice for adult men in terms independent of gender, was, therefore, logically inseparable from the gender system:

> It distributed to men and women different kinds of desires, construing male desire as wide-ranging, acquisitive, and object-directed, while construing female desire (in opposition to it) as objectless, passive, and entirely determined by the female body's need for regular phallic irrigation. Instead of viewing public and political life as a dramatization of individual sexual psychology, as we often tend to do, they see sexual behavior as an expression of political and social relations" (pp.36-37).

The Middle Ages

With the fall of the ancient world and the rise of Christianity, a very different relationship arose between the body, sexual acts, society, and the cosmic order (Carroll, 1996). In the ancient world, there was little thought of an eternal life. All good things could be found on earth. Carroll notes that with the rise of Orphism (a late classical phenomenon) and then Christianity (which was largely based upon Orphic ideas) came the idea of other worldly redemption:

> Mundane life was seen as a life of sin. Mortification of the flesh was needed to purify oneself from sin in this world in order to obtain a place in a paradise after death. From writers such as St. Paul to St. Augustine and beyond, a new

> sexual ethic was being developed that stressed abstinence except for the minimal act needed for procreation within marriage. All pleasure was suspect. The body was de facto contaminated, evil, puerile. Any attention paid to it was sinful (p.118).

According to Highwater, (1990) the apostle Paul was outspoken on the matter of the opposition of flesh and spirit. "The flesh lusts against the spirit and the spirit against the flesh; and these are contrary to one another ... For to be carnally minded is death; but to be spiritually minded is life and peace." (Gal. 5:17; Rom 8:5).

The procreative act was often seen as something to be reviled. Lacquer notes, "Intercourse, argued Pope Innocent III, is a diatribe against the body, is never performed without 'the itch of the flesh, the heat of passion, the stench of the flesh" (p. 140).

Unsurprisingly, such a difficult ethos was slow to take hold and the ancient view (now 'pagan') continued alongside the Christian until the Renaissance and beyond. According to Lacquer:

> ... it was 'common knowledge' well up to the nineteenth century that in order to impregnate a woman, a sufficient degree of 'heat' generated by sexual passion was a vital ingredient: Desire then was a sign of warmth and female orgasm a sign of its sufficiency to ensure 'generation in the time of copulation' (p.102).

This clearly ran counter to the church's injunction to 'cool it'!

According to Boswell (1980),

> ... it was not until the twelfth century that specific prohibitions against acts such as pederasty (which referred to 'unnatural' male and female sex acts) were proscribed and enforced. Indeed, until that time, same sex partnerships could be officially sanctioned by the church with a ritual proscribed for such unions. (p. 36)

Boswell attributes the change in Church attitudes to the rise of a middle class that needed to vilify an entrenched aristocracy and aristocratic values, which for the most part continued a more pagan, ancient tradition. Free wheeling sexual license was associated with a leisured upper class. Religious reformers, who usually had the support of the middle class, such as Savarolona, often vilified homosexuality, which was associated with a more educated, liberal upper class (Carroll, 1996).

Saslow's study of homosexual iconography in Renaissance Italy describes a scene compatible with that discussed above. Saslow finds it remarkable that this clash between classical learning and Christianity is marked by profound differences between the various

courts as to what constituted acceptable behavior. The influence of specific leaders and their attitude towards sexual mores and behaviors were very dramatic and could vary within principalities that were only a few miles apart (Saslow, 1986).

Saslow notes that the upper class was vilified as decadent by the middle class, often with the help of a highly politicized church that was more than willing to capitalize on such dissatisfaction as a political issue within the quickly changing landscape of alliances that was Renaissance Italy. In his large-scale cross-cultural and historical investigation of the social construction of homosexuality, Greenberg stresses how the supposed decadence of the ascendancy became a recurrent theme in the continuing war between the classes, with the emergent bourgeoisie consistently on the winning side:

> The increased repression of homosexuality in the late Middle-Ages can be traced to two distinct but related sources: church-state conflict and class conflict. With regard to the former, it will be argued that the growing preoccupation with homosexuality was an indirect and unanticipated consequence of the efforts of church reformers to establish sacerdotal celibacy. With regard to the latter, it will be suggested that a popular hostility toward homosexuality was part of a broader middle class morality that became increasingly forceful in its opposition to a lifestyle of luxury and excess as class divisions widened (p. 280).

However, Carroll notes that:

> ... the ancient model of a more diffuse notion of sexuality continued in the secular courts, which continued to grow during the late Renaissance. This period saw a dramatic increase in highly ritualized court life. Power was increasingly centralized and men and women of the upper class were increasingly in daily contact, a situation which threatened to undermine the older, all male society of the ancient world (p. 208).

Two hundred years after the fabliaux, the all-male world of the aristocratic warrior class had waned. Courts were still overwhelmingly male, but more was required of the courtier now than military prowess and naked brutality. Political and social success depended not only on might and cunning but on the gentler skills of courtesy, dress, conversation, and the skills of 'self-fashioning' (Lacquer, 1990, p.125).

However, such close contact with women and a crossover of social skills between men and women also engendered new anxiety concerning the power of patriarchy, the power of the male over the female, and of male-male relationships (Carroll, 1996):

> The modern question, about the 'real' sex of a person, made no sense in this period, not because two sexes were mixed but because there was only one to pick

> from and it had to be shared by everyone, from the strongest warrior to the most effeminate courtier to the most aggressive virago to the gentlest maiden. Indeed, in the absence of a purportedly stable system of two sexes, strict laws of the body attempted to stabilize gender – woman as woman and man as man – and punishments for transgression were quite severe (pp.124-125).

Writers such as Bray (1988) and Goldberg (1994) suggest that male-male relationships continued in an idealized and elevated position according to the model inherited from the classical world. After the Renaissance, however, there was increasing scrutiny of the exact nature of these relationships. Sodomy – which referred to any sexual act outside marriage – was always a hovering guest at the border of intense male relationships. "Within this world, however, power still equaled sexual access and prowess: the greater the increase in power, the more multifarious the opportunities to exercise one's sexual peculiarities" (Carroll, 1996).

> A charge of sodomy almost always had a political context and was frequently directed toward a political rival. It was hardly worth bringing the charge against an inferior; one dare not bring it against a superior. If one had sufficient power, colonization of underlings went without notice (Goldberg, 1994, p.42).

The life of the Marquis de Sade – the sexual colonialist par excellence – as illuminated by Lever (1991) offers an intimate look into the rapacious possibilities of aristocratic power when the lower classes existed simply for upper class enjoyment. What is remarkable to us now, noted Carroll, is how 'natural' this exploitation seemed at the time. Society was still profoundly hierarchical. To know one's place was to know who one was. The approach of Descartes' cogito in the next century heralded a stunning reversal of seismic proportions (Carroll, 1996).

The Enlightenment

The modern era brought to Western civilization a radical change in outlook toward many things, including sexuality. Carroll offers a noteworthy review of the evolution of this new outlook towards sexuality and sexual orientation which offers powerful insights into how we come to be where we are today in Western Europe and North America with our sexualities.

> The beginning of the seventeenth century in continental Europe and England saw the fruition of the accelerated cultural growth that had been the hallmark of the Renaissance and the resulting Copernican revolution in the new relationship between individual and state that became known retrospectively as the 'Enlightenment'. At this time the modern notions of the individual and individual

rights came into being. The larger cosmic order, whether classical or Christian, was assaulted by a new rationalism based on science that no longer ordered individuals according to paternity, class, race, or immortal soul. Man, the pinnacle of creation, was becoming man the animal. The rights of the aristocracy were intellectually and physically challenged throughout Europe, and the foundations of traditional patriarchy were shaken by events such as the French revolution. The ordering meta-structure of race, class, gender, and religion, which had been the bedrock of civilization for millennia, was increasingly destabilized in a rising new order.

Central to this new order was the very idea of the individual. No longer did the slave make the man, but rather a man – a thoughtful and rational man (as defined by the cogito ergo sum of Descartes) was enslaved. The individual became key: an individual who hypothetically existed apart from culture, language, and history. Society arose because of the social contract it had with autonomous individuals, who were willing to sacrifice part of their autonomy for the advantages of culture and congeniality. However, Man, – in his essence – was free. This view contrasted starkly with the previous view of man as zoan politikon – the political animal of Aristotle, who was created though interaction with society. Neither did man remain the pinnacle of God's creation according to a sliding scale of perfection that started with nature and rose up through the animals, women, and boys to men.

The emerging, modern view of the individual, however, also created an ideological conflict between the individual and society which is manifested in two major variations. In the vision offered by Rousseau, man was essentially good – a noble savage. Society was a corrupting influence on the natural nobility of man. Hence, society was a repressive force to be fought at every turn. For other writers such as Hobbes (and later Freud), man was a violent animal, and society was necessary to ameliorate his violent tendencies. Society needed to be repressive in order to protect man from the worst in himself. These views had one thing in common: they created an imaginary duality – man in nature (whether violent or benign) versus man in culture. It was the vision of man in nature (the free man before the coming of the law) that allowed the creation of the leading myth of the day: all men are created equal.

However, such an assertion was not articulated without society. Certainly, to the rising bourgeoisie, all men with money, with capital to invest, were equal ... and why not? Capitalism needed a free market made of free agents in order to survive. In addition, it was to the bourgeoisie that these freedoms were first extended. The rhetoric of the American Declaration of Independence still granted suffrage only to the wealthy. It was not yet meant to encompass people who were treated as property (women and slaves). However, these distinctions, too, began to break down. If women were, even hypothetically, 'free', how was the old patriarchal kinship order to reproduce itself? How were gender roles, the bedrock of kinship and male authority, to be justified in this changing order? (Carroll, 1996; pp.226-227)

Trumbach elaborates on the cultural upheaval:

> I think that what we are describing is the beginnings of a major cultural shift, which is still far from complete. A patriarchal morality that allowed adult men to own and dominate their wives, children, servants and slaves, was gradually challenged and partially replaced by an egalitarian morality which proposed that all men were created equal, that slavery must therefore be abolished, democracy achieved, women made equal with men, and children with their parents (p.117).

However, as Lacquer (1990) insightfully points out:

> ... rather than becoming the foundational bedrock of a new order, science became the new justification of the old order. Patriarchy and the saliency of gender roles were upheld by using science as the lens through which a 'natural' order could replace the previous 'cosmic' one. However, science seldom had all the answers. Instead there arose 'an imagined biology' in which women were found, conveniently, to be the 'weaker of the sexes' while men were found to be 'naturally aggressive' (p.28).

According to Lacquer, men and women were now seen to be biologically different on a fundamental level. Sex arose as this absolute difference. The 'two sex' model replaced the 'one sex' model. The hierarchical gave way to the horizontal. Women were no longer 'defective males' but an absolute other, a biological world unto themselves. Anatomy was now destiny (Carroll, 1996).

> In an age obsessed with justifying and distinguishing the social roles of women and men, science seems to have found more than just signs of sexual difference in the disparate forms of the penis and the vagina. Instead, it saw the very basis of difference, representing the web of heterosexual union on which reproduction, the family, and civilization itself appeared to rest (Carroll, 1996, p.207).

However, Lacquer is also quick to point out that at that period science had little actual proof of many of the claims that it was making about gender roles and absolute differences between men and women. Rather, science *became* myth.

> The ways in which sexual differences have been imagined in the past are largely unconstrained by what was actually known about this or that detail of anatomy or physiological process, and instead derive from the rhetorical exigencies of the moment. Basically, the content of talk about sexual difference is unfettered by fact, and is as free as mind's play (Carroll, 1996, p.209).

Implications for Homosexuality

As Carroll himself points out, these scientific claims had important practical implications:

> Men now desired women (and vice versa) because of a preordained biology. If sex with men was like sex with women, then the men who have this sex must be like women. Before, such an idea was not a problem, because women were simply an inferior type of men, and sex in general was thus fundamentally homosexual. However, with the 'two sex' idea, men who had sex with men were now seen as women. In other words, they were a totally different species. There was no way to cross this absolute divide (p. 210).

In addition, with the breakdown of the old social order, a new social contract that would tie woman inextricably to man was needed. Sex, seen from a biological standpoint, became the justification for this order. Correct gender behavior now became correct *heterosexual* behavior. Men and women were biologically made for each other and only for each other. Within the two sex models, heterosexuality arose as the only sexual option that satisfied strict gender roles and that would reproduce civilization. In other words: "sex, gender, and sexuality were locked together as the biological imperative" (Weeks, 1985).

Hence, for the first time, a male who performed homosexual acts became *de facto* feminine, regardless of whether he was an active or passive partner, young or old. It was this fear of the 'woman' in man that led to its exorcism through the emergence of a new class of man who was no man at all (Dollimore, 1991).

According to Trumbach (1989):

> ... such a transition did not happen overnight, but was more or less in place by the mid 1700s. Around this time, public meeting places called 'molly houses' appeared in major urban centers, catering to this new style of creature, the 'effeminate sodomite'. Homosexual acts, in any of their permutations, became a clear indication of a transgression across a conflated sex/gender line. To transgress this line was now to invert the natural order. Homosexuality became 'the crime against nature' (p.47).

The female transvestite was perceived as a deeply disturbing figure in the early seventeenth century. Certain cultural distinctions were breaking down and in the anxiety that they provoked we read the effects of far-reaching historical change. In obsessions with dress and its social significance we witness contemporary tensions and struggles between classes, between residual and emergent cultures, between the mercantile order and what it was actually (or seemed to be) replacing, between rank and wealth, and between innate and fiscal value (Dollimore, 1991, p.103).

In the emergent market economy, class could be bought, fancy clothes could be bought, male status and privilege could be bought. Everyone was a potential gentleman, a patriarch, a real man. The lower classes were no longer seen as the sexual playground of the rich. The sexual colonialism of lower class men, which had previously been pervasive as an enactment of sexed social roles, was now a transgression against individuals who might be exploited (Carroll, 1996, p.212).

Again according to Trumbach:

> ... the need to inscribe homosexual acts and attributes associated with them with effeminacy emerged. The sodomite had become a symbol of failed masculinity and as such, began to occupy an increasingly important symbolic position as an ever more visible threat to the social order. The newly emerging class and gender tensions that were well on their way to creating exclusive heterosexuality also created the tension and anxiety that created a more exhaustive and highly visible homosexual deviant (p.48).

Conversely, sex became a market commodity to be bought and sold like any other. In the free market economy of the eighteenth and nineteenth centuries, social forces, with appeals to nature at every turn, were applied to keep sex out of the marketplace and within socially acceptable institutions. A science of sexology arose to create, define, and ultimately control sexual behavior and mores (Carroll, 1996).

Concurring with this theory, Weeks (1985) remarks:

> Just as the foundation of sociology in this period sought, through the writings of August Comte, Karl Marx, Herbert Spencer, Emile Durkheim, Max Weber and many others, to find the 'laws of society', so, in a complementary and equally influential fashion, the early sexual theorists attempted to uncover the silent whisperings, the hidden imperatives of our animal nature "on account of its ... deep influence upon the common will." The science of sex was a necessary adjunct to the science of society; each came to rely implicitly but absolutely, on the other. A dichotomy between 'sex' and 'society' was written into the very terms of the debate (Weeks, 1985, p.339).

The emergent significance of "the family", as one vocal group in particular is pointed out by Carroll:

> As the metaphysical underpinnings of society collapsed, as history lost its prescriptive power, as law was being reduced to custom, to group consensus, one last bastion of un-assailed order emerged: the family. The nuclear family was made to carry the recreation of the patriarchal order and science was used to justify the 'naturalness' of the gender roles reflected in the bourgeois family and the 'naturalness' of genital desire within marriage. As metaphysics were

> withdrawn from society, they were reinvested in the family. The King was no longer a god, but every man was a king, every woman an Eve, every family a recreation of the entire cosmic order of creation. There was a grand reversal of metaphor: what previously had been writ large on the outside of the social order (distributed through God, king and country), was now to be found written inside individual psyches. Cultural mythology was quickly collapsing into individual psychology, and the family was on its way to becoming its executioner and scribe. Unsurprisingly, sex outside the family was vilified and there was a growing condemnation of masturbation, prostitution, and homosexual acts (p.213).

It is often thought that the eighteenth and nineteenth century obsession with masturbation and prostitution were part of a new literature "dominated by a tone of total and repressive sexual intolerance" (Carroll, 1996, p.213). Lacquer argues instead that the 'solitary vice' and the 'social evil' were believed to be, as their new names imply, social pathologies that visited destruction on the body in the same way that blasphemy and lechery were seen to produce monsters in ages past.

Weeks (1985) notes that many of the new categories created by sexologists accurately recreated classifications "nearly identical with theological classifications and with more pronouncements of the English common law of the 15th century." With the growing tension between sex and society, and between individual and society, it was inevitable that sexual deviance would be transferred from the acts themselves to the individual: " ... the eruption of the speaking pervert, the individual marked, or marred, by his (or her) sexual impulses" (Weeks, 1985). The pervert now became the border of the normal (Carroll, 1996). The cataloging of case studies and creation of new categories of deviants, such as the sadist, the masochist, the fetishist and the newly minted 'homosexual' began at the turn of the twentieth century with the efforts of sexologists such as Kraft-Ebing, Hirshfield, Bloch and others (Foucault, 1978). "The 19th century homosexual became the personage, a past, a case history, and a childhood, in addition to being the type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology" (Foucault, 1978).

> Thus, a crisis in the 'natural' order of the old patriarchal kinship structure created a conflation of gender and sexuality into a new character type, the homosexual, who had a definable psychology and identity. Over the next century, the identity of the homosexual underwent several shifts and reversals from its origins as a perverse character flaw to being a criminal activity that should be excised from society. In turn, homosexuality would be described as: 1) a mental illness, 2) a natural, biologically based variant of human behavior, and 3) a revolutionary term to be turned back on a bourgeois, paternalistic order that had

created the term to safeguard heterosexuality. As we shall see, each of these belief systems created vastly different expectations for the normative development and maintenance of homosexual identity (Carroll, 1996, p.221).

A Queer Century Summarized

Carroll summarizes the twenty-first century for the American gay and lesbian community as an:

> ... odd time of transition. It is a time of paradox, change, fragmentation, and reflection. As gay publications, gay organizations, gay churches, etc. have flourished, so have gay positions on just about everything, including the economy, politics, religion and academics. Some gays have become an entrenched part of the middle classes away from the more radical hubs of gay ghettos in major urban centers. These gays often espouse a growing conservatism, and tend to opt for quiet assimilation. Others, mostly within larger urban centers, are still fighting the seemingly endless battle against AIDS, both outside and within the institutional mainstream. Some have taken up specific causes, such as transgender rights or S&M. The community seems to have grown to encompass a very loose 'patchwork quilt' of local causes, communities and interests. Once again, gays are both everywhere and nowhere. The very notion of a unified 'gay identity' seems like some quaint idea from the past. For some, this is a reason to mourn, but for others, the de-centered nature of the community points the way to a more empowered, postmodern future (Carroll, 1996, p.223).

Queering the Future

Carroll notes that the vast majority of interests for gay and lesbian studies have been:

> ...retrospective; the unearthing hidden histories, silenced voices, and sequestered knowledge. This unearthing has questioned the foundational roots of heterosexuality, which is now seen as a social construct and biological phenomenon, providing a founding myth for the legitimization of gender roles. It has also enriched gay and lesbian lives immeasurably, providing an *iprimatur* and *nihil obstet* for their very existence (Carroll, 1996, p.224).

However, it has been suggested (Carroll, 1996) that:

> ... the weight of this scholarship has prompted the lesbian and gay community to move its sense of identity beyond the reactionary politics of the 1970s and 1980s. This is identified specifically as a move toward questioning heterosexuality and the primacy of the masculine gender role, not defensively ('We are just as good as you') but from an offensive position affirming gay relationships as models for future relationships within society at large. For example, the gay egalitarian relationship, in which both partners work, share household duties, etc. offers an interesting model of how one gender can include all the various attributes that society has provided for both (e.g. nurturance,

assertiveness, support, leadership, etc.). In this regard, gay men and women offer a positive model for everyone, acknowledged only recently.

In addition, those within the gay community who traverse traditional gender lines, such as the 'boy identified lesbian', anticipate the increased blurring of gender possibilities within culture at large (e.g. mixed contact sport teams, female police officers). They are also active in the creation of new possibilities that may be introduced to the general population.

Lastly, the many gays and lesbians who move to urban centers and live and work within gay communities offer a model of community that challenges the traditional barriers of public/private, individual/group and work/life space. In addition, the lack of a closely defined identity within the community offers a model for multi-cultural awareness and the politics of inclusion. In many ways, the gay and lesbian community has just begun to be discovered and valued for the creative social laboratory it is, offering a great deal to culture in general (pp.225-226).

The Twentieth Century in Review

The current organization of homosexuality is a culmination of a century of slow evolution away from a gender-based organization to a modern, middle class organization based upon exclusive sexual object choice (Weeks, 1985). This split was originally based upon the vilification of homosexuals and the creation of a heterosexual normative ideal (Carroll, 1996), and it is a relatively modern creation that only reached saliency in all classes in the 1950s. Subsequently, an organized resistance to the pathologizing of homosexuality arose (with, however, the tacit acceptance of the categories hetero and homo) as well as active pursuit of the creation of a positive gay identity. This new gay identity, however, was mainly of interest to white people from the middle classes (Weeks, 1985). Older forms of sexuality, such as gender-based identifications, as well as other categories of identification, such as race, continue to operate in other subcultures as the major substrate of identity. Nonetheless, within traditional mainstream psychology, the middle class norm continues to be uncritically applied (Carroll, 1996).

Today, there is a need for a detailed inquiry into the ideological assumptions behind the normative ideal of 'the good homosexual' and our step-by-step exploration of Cass' developmental stages. Carroll suggests that the unspoken assumptions that underlie the schema spring from the bourgeois notion of the anxiety- and contradiction-laden individual and that, ultimately, such a schema supports a conservative agenda very much in line with the conservative, middle class agenda of mainstream psychology and psychiatry.

Chapter 13: Queer Theory

Queer and lesbigay stakeholders in the ethical debate on sexual reorientation often operate from a political and philosophical perspective born of the queer theorists. To fully understand the drive behind objections to sexual reorientation some familiarity with queer theory is required. Queer theory is a recurring theme in non-heterosexual philosophy and politics. Any analysis of the clinical or social implications of sexual reorientation interventions involves discussion of themes from queer theory and queer philosophers.

In its broadest sense, queer theory concerns itself with the overarching theme of how sexual minorities have forever been made to create meanings by those who wield political, scientific and cultural power, and how such meanings are externally and, eventually, internally enforced, so as to seem natural, inevitable, and necessary to civilization (Butler, 1993). Its concern is to examine in depth the social, political, and personal forces that combine to create a fixed sense of self-identity with the goal of uncovering the mutability of these identities and making accessible possible sites of individual and cultural transformation (Jagose, 1996). According to Fradenburg and Freccero (1995):

> It is impossible to overemphasize the importance of the concept of historicity to queer theory and other critical enterprises devoted to dismantling the universals, essences, and natures that have for centuries been used to define and persecute 'others' (p.375).

Identity, within this historical perspective, is not a fixed 'essence' but something that reflects the combination of the individual character and the story within a temporal framework. The power of such a critique lies in its ability to subvert the dominant mythology through the positing of alternative readings of 'how things came to be' (Carroll, 1996). The new narratives of queer theory provide avenues for growth on both the individual and cultural levels. In the words of Paul Ricoeur (1992):

> The person shares the condition of dynamic identity peculiar to the story recounted. The narrative constructs the identity of the character, what can be called his or her narrative identity, in constructing that of the story told. It is the identity of the story that makes the identity of the character (pp.147-148).

Queer theory explores the history that has resulted in the current situation of today's homosexual and offers insights into modern gay identity as well as the struggle of the non-gay homosexual and the many other sexual minorities (Carroll, 1996). Many of the premises

which underlie contemporary sexual identity are historically unexamined and have remained unchanged for centuries.

The Genesis of "Queer" as a Theory

Oddly enough, Nietzsche is the grandparent of queer theory. According to Carroll, the historical inspiration for such a critique dates from the works of Nietzsche with his draconian 'revaluation of values' in the late nineteenth century. Nietzsche dramatically detonated the tenets of high modernism - the possibility of universal truths, clear moral imperatives, and the grand evolution of civilization away from the mytho-poetic realm to the exalted realms of pure science. Nietzsche (1887) saw only contingencies, power, and perspective:

> There is only a perspective seeing, only a perspective 'knowing'; and the more affects we allow to speak about one thing, the more eyes, different eyes, we can use to observe one thing, the more complete will our 'concept' of this thing, our 'objective' be (p.503).

The world, for Nietzsche, is not composed of facts – a positivist notion – but rather interpretations that clash against each other while vying for a claim to attention – for vindication. In short, to rule undisputedly (Carroll, 1996). Nietzsche's philosophy cannot be understood without considering his essential pluralism. There is no event, no phenomenon, word or thought which does not have a multiple sense (Deleuze, 1962).

Most of Nietzsche's work centers specifically around traditional Judeo-Christian morality (Carroll, 1996). He attempted to re-historicize this tradition, thus showing its contingent nature – its creation through the historical machinations of 'will to power' (Nietzsche, 1901). As a result, he re-examined most values from the perspective that history was no longer inevitable, but a function of the will to power:

> The maxim of 'knowledge is power' dated back to Sir Francis Bacon and the dawn of the age of enlightenment and the high modern period. Nietzsche reversed the equation to begin the postmodern inquiry based on the maxim 'power is knowledge' (Carroll, 1996, p.227).

Foucault

Michel Foucault, the French philosopher and psychologist, turned the study of power and knowledge towards an understanding of sexuality, using the foundation laid by Nietzsche. Foucault 'historicized' the naturalness of our modern ideas of sex, making of them a natural

category to be studied, cataloged and controlled. From Foucault's perspective, we see nature giving way to culture throughout history (Carroll, 1996).

Many gay writers in the 1970s, such as Katz (1976), Altman (1971), and Weeks (1977), as well as many feminist and lesbian writers, had been exploring the idea that sexual categories that appear natural and inevitable (such as male/female, masculine/feminine, heterosexual/homosexual) are actually historical creations bound to a particular place and time. Katz, among others, has been vocal regarding the trend among 'queer philosophers' to glorify the contributions of Foucault prematurely.

> Foucault, however, was the first to place such questions into a larger philosophical tradition that linked such historical inquiry to larger issues of epistemology, power, and truth. He showed how the social sciences claim objective truth, yet are complicit with the maintenance of the *status quo* of a bourgeois, patriarchal power regime (Carroll, 1996, p.226).

For Foucault, it was the category of 'sex', that provided these regimes with their most invasive instrument of control.

From Ancient to Modern Alliances

Foucault (1984) marked the seventeenth century as representing the initial transition away from ancient, aristocratic patriarchal power structures, based on traditional 'deployment of alliance', such as a hierarchical caste system and marriages based on long standing family alliances (and hence, non-romantic, impersonal, and political). He describes the subsequent order as a bourgeois structure based on the 'deployment of sexuality', such as the need for monogamy, strict sexual orientations, and a list of approved sexual acts (Carroll, 1996).

In aristocratic society, marriage was first and foremost a societal contract, devoid of romance, spirituality, and passion. Alliances and the property they represented were meant to span generations in a meaningful and steady course (Boswell, 1994). Although sex was necessary for the creation of an heir, romance was a threat to the order of the system. Outside marriage, individual sexual desire was free to roam across a variety of borders so long as the basic tenets of the contract, such as the creation of an unchallenged heir, were not broken (Carroll, 1996). For the lowest classes, marriage was barely a consideration and knowledge of who one's true parents were was often a moot point. Hence, patriarchy and class constructed long-term relationships, not erotic desire (Foucault, 1978).

> With the rise of the bourgeois society, the complete control of the ruling elite gave way to the freedoms of the common-man. The Age of Enlightenment undid 'the great chain of being' wherein people had been able to find their place (and identity) along a continuum of power that started with God and ended with slaves. Instead, the Enlightenment offered the notion that 'all men are created equal'. The individual was created with certain unalienable rights. Identity that had previously been handed to the individual at birth (e.g. sex, name, rank, profession), now became an interior 'tabula rasa.' Accordingly, once-stable alliances were in danger of disintegrating into a dangerous, disordered flux by theoretically autonomous individuals who could order alliances willy-nilly (Carroll, 1996, p.129).

Hence, according to Foucault, the individual human body now became a machine to be structured and controlled by the ruling bourgeoisie. By extension, the community became a populace in which the government was concerned with propagation, birth, mortality, the level of health and life expectancy (Foucault, 1978). The older power of the sovereign, with control over life and death, was now transformed into a bourgeois administration that exerted control as seamlessly as possible through all aspects of personal and community life (Carroll, 1996). According to Foucault, sex became the key to this ordering, and sexual desire the glue that held it together. Sex became a subject of expert medical, religious and psychological discourse, a discourse that ran through the body and soul of each individual, ensuring an absolute source of control from which none could escape (Carroll, 1996).

> The deployment of sexuality has its reason for being, not in reproducing itself, but in proliferating, innovating, annexing, creating, and penetrating bodies in an increasingly detailed way, and in controlling populations in an increasingly comprehensive way (Foucault, 1978, p.122).

Foucault refers to what he calls the 'notion of sex' as 'an artificial unity', that was lumped together out of sensations and pleasures in order "to make use of this fictitious unity as a causal principal, an omnipotent meaning, a secret to be discovered everywhere" (p.154). According to Foucault, 'sex' was an 'imaginary point' that was posited prior to sexuality by the regimes of power that organized sexuality. Each individual had to pass through the absolute category of 'sex' and be named unequivocally a male or a female in order to have access to a body, which is now sexed and an identity, which is now based on sexuality:

> We arrived at a point where we expect our intelligibility to come from what was for many centuries thought of as madness (the vicissitudes of Eros) ... from what was perceived as an obscure and nameless urge" (Foucault, 1978, p.156).

To Foucault, the nuclear family, originally universalized in support of the bourgeois state, is the premier bourgeois institution, one that has been invested as the site of power and control. To queer theorists, sexual desire, once poly-vocal and free ranging within certain exterior limits, was made to reside within the drama of the family and subjected to internal limitations, such as a fixed opposite sex orientation, and delimited to a strict reproductive imperative (Carroll, 1996). The rising bourgeoisie vilified sex that was not strictly reproductive in intention (Carroll, 1996).

For Foucault, Freud's work, with its excessive emphasis on psychosexual development grounded in biology, represented an excellent example of how the prevailing tide of nineteenth century science allowed the bourgeoisie agenda to delimit and control alliances. Freud's Oedipus complex was the logical culmination of such a conflation of a nuclear family, sex, desire, and a reproductive imperative (Foucault, 1978). Queer theorists note that submission to the law was no longer an external obeisance to a powerful ruler, but an internal submission through a complex interplay of relinquishment and identification (Carroll, 1996). Western culture became dependent on the inner workings of the nuclear family and the sublimation of incestuous strivings within that family (Butler, 1980).

Where Freud saw the repression and sublimation of primitive sexual drives as necessary for the creation of culture, Foucault saw production – the production of the repressive regimes of bourgeois power and control. Psychology, for Foucault, created riddles – such as the Oedipus complex in psychoanalysis – in order to answer them and thus obtain authority over the persons who have been explained:

> This convoluted psychological discourse – itself a prodigious production, when legitimized by regimes of power, such as a psychoanalytic elite (or social elite, such as politicians, city planners, prison wardens - the whole panoply of bourgeoisie positions of power), ensured an intrusive control that penetrated the inner psyche of every citizen. Sex as a secret in need of an explanation became the democratic illness – are we not all castrated? And discourse about it – the cure. Eventually, the need to have a stable sexual orientation that remained stable over time (or whose truth was unearthed and developed through therapy) became a shibboleth of modern culture, a way of giving 'body and life to the rules of alliance by saturating them with desire' (Foucault, 1978, pp.98-99).

Foucault argues that power is not a unitary phenomenon, incapable of change. It is the result of multiple alliances and smaller power structures, each with its own unstable base. The result is an overlapping and often contradictory matrix of injunctions and proclamations

(Carroll, 1996). For Foucault, this dynamic view of power also allowed for the possibility of change. Every restriction could become a point of resistance. Every dictate, fiat, rule created the possibility of its opposite, the seat of its own undoing. According to Sheridan (1980):

> Power relationships depend on a multiplicity of points of resistance, which serve at once as adversary, target, support, and foothold. Just as there is no center of power, there is no center of revolt, no unified class of the seat of rebellion. There is a plurality of resistance (p.185).

Foucault returns us to Nietzsche's notion of plurality and its transformational potential (Carroll, 1996).

The Queering of Identities

In recent decades there has been an explosion within popular culture of writers, artists, performers, philosophers and social scientists speaking from gay, lesbian, queer, and other marginalized perspectives. This intentional, sometimes promiscuous performance of dislocated, multiple sexual identities continues to create an ongoing 'queering' of familiar identities and stories. It is worth quoting a number of authors here to provide a sense of what is involved:

Sedgwick (1993) emphasizes:

> That is one of the things that 'queer' can refer to: the open mesh of possibilities, gaps, overlaps, dissonance, and resonance, lapses and excesses of meaning when the constituent elements of anyone's gender, of anyone's sexuality aren't made (or can't be made) to signify monolithically. The experimental linguistic, epistemological, representational, political adventures attaching to the way many of us who may at times be moved to describe ourselves as (among many other possibilities) pushy femmes, radical faeries, fantasists, drags, clones, leather-folk, ladies in tuxedoes, feminist women, feminist men, masturbators, bull-daggers, divas, snap queens, butch bottoms, storytellers, transsexuals, aunties, wannabes, lesbian-identified men, lesbians who sleep with men, or ... people able to relish, learn from, or identify with such (pp.298-299).

Carroll holds the view that:

> The queer approach to sexual identity expands on many of the ideas that originated with Nietzsche and Foucault. It emphasizes the unstable state of apparently natural categories such as sex, gender, and orientation. Exposure of the inherent instability of these 'natural' categories makes change and transformation on individual and cultural levels possible. The 'queering' of identity is the conscious taking on of many contradictory roles ('butch bottom') as a political act (p.158).

Butler (1993) asserts that:

> "If the term "queer" is to be a site of collective contestation, the point of departure for a set of historical reflections and future imaginings, it will have to remain that which is, in the present, never fully owned, but always and only redeployed, twisted, queered from a prior usage and in the direction of an urgent and expanding political purpose" (p.73).

Carroll correctly emphasizes that:

> The term 'queer' itself remains controversial within the gay community. There are many (often middle aged), middle class gays who eschew the appellation altogether, mostly because of its profound negative cultural connotations. Others consider 'queer' to be a term which is accessible to everyone through an active act of interpellation – 'I am queer in my multiplicity of identities'– but one that belongs to no one group, lifestyle or set of political objectives (p.240).

According to Halperin (1995),

> ... queerness is a "new kind of sexual identity characterized by its lack of clear definitional content ... not by what it is, but by where it is and how it operates. Those who knowingly occupy such marginal locations, who assume a de-essentialized identity that is purely positional in character, are properly speaking not gay but queer" (pp.61-62).

Queer theorists are less concerned with a unified 'doer' behind the deed, than with the collection of deeds themselves (Carroll, 1996):

> Where there is an 'I' who utters or speaks and thereby produces an effect in discourse, there is first a discourse, which precedes and enables that 'I' and forms in language the constraining trajectory of its will. Thus, there is no 'I' who stands behind the discourse and executes its volition or will through the discourse (Butler, 1993, p.109).

The Postmodern Homosexual

Queer's investigation into the development of modern gay identify is evidenced, according to Carroll by:

> ... multiple stories and perspectives, and an emphasis on the discontinuities of the epistemes (truth claims) over the course of history, rooted in postmodernism. Complexity is valued over the creation of an overarching, bird's eye, grand narrative *a la* Hegel, or the crushing equanimity of consensus *a la* Habernas (p.241).

According to Carroll (p.156), the result is what Lyotard (1979) calls a "pairology" or "the double observation of the heterogeneity of rules and the search for dissent."

Interpreting texts, regardless of the person involved, does not seem to be simply a matter of some arguments defeating others, but of the expansion of ideas, alteration of practices and general self-education (Hoy & McCarthy, 1994):

> In this regard, a 'queer' education, with its emphasis on illuminating the previously hidden, the silenced, and the left behind, creates the ground from which new narratives, new identities, new cultural forms can arise that can have transformational potential on a personal and collective level (pp.114-115).

The exploration of the creation and development of the modern homosexual as a cultural form begins with the exploration of a diachronic, historical investigation of male homosexual acts within their social context (Butler, 1993). Carroll (p.162) describes the major homoerotic themes woven throughout our Western histories:

- Same-sex erotica as the glue of a patriarchal, male dominated culture.
- Same-sex erotica as the basis for ideal friendship.
- Same-sex erotica as sexual colonialism within a rising market economy.
- Same-sex erotica as abomination outside the law of reproduction.
- Same-sex erotica as 'inversion': evidence of a female in a male's body.
- Same-sex erotica as a threat to a patriarchal, male dominated culture.
- Same-sex erotica as a recognized character type – 'the homosexual'.
- Homosexuality as genetically inherited.
- Homosexuality as acquired through the family.
- Homosexuality as an illness without a cure.
- Homosexuality as a curable perversion of choice.
- Homosexuality as a hysterical border for heterosexuality.
- The 'homosexual' as sexual outlaw and rebel.
- The 'homosexual' as a political force.
- The 'homosexual' as unremarkable variation of sexual desire.
- The 'homosexual' as just another family down the block.
- The 'homosexual' as a dire threat to 'family values'.

Carroll demonstrated that such themes reflect prevailing prejudices as well as the ethical imperatives of their times, and that many of these continue to resonate in contemporary society and impact public policy and prevailing public opinion. With the expansion of the boundaries of identity categories, and in seeming to diminish, discredit, and disregard distinctions between the various forms of marginalized sexual identification, 'queer' has provoked exuberance in some quarters, but anxiety and outrage in others (Weeks, 1990).

Queer Skepticism

Queer's discredit of the 'self-evident' status of identity categories has itself come under suspicion from those who see it as merely a political or even a reactionary form of intellectualizing (Jagose, 1996). A bioethical analysis of sexual reorientation interventions will necessarily need to examine both sides of queer theory and its clinical utility. At the extreme are Wolfe and Penelope (1993), who introduce their anthology of lesbian cultural criticism by identifying the destabilization of identity as an explicitly homophobic strategy:

> We [cannot] afford to allow privileged patriarchal discourse (of which post-structuralism is but a new variant) to erase the collective identity Lesbians have only recently begun to establish. For what has in fact resulted from the incorporation of deconstructive discourse, in academic 'feminist' discourse at least, is that the word 'Lesbian' has been placed in quotation marks, whether used or mentioned, and the existence of real Lesbianism has been denied, once again (p.23).

West and Zimmerman (1997) make an anxious observation that "the discourses of 'common sense' and contemporary theory seem to be moving further apart." This observation has been used to discredit the role of queer theory in any debate on the ethics of sexual reorientation. Palmer (1993) and Castle (1993) express similar distress in critiquing the way in which it has become popular to contest, along deconstructionist lines, the very meaningfulness of terms such as 'lesbian' or 'gay' or 'coming out', especially among younger lesbian and gay scholars trained in Continental philosophy (including a number of queer theorists). In a critique of Castle, Traub (1995) argues that such claims ignore the ideological dimension of an appeal to common sense:

> The assumption that one knows, in an 'ordinary', 'vernacular' sense, what a 'lesbian' is, and that on the basis of such a stable knowledge one can forge connections across time and culture, obscures the recognition that such knowledge is less a position from which one can make autonomous claims than the result of normalizing discourses (p.29).

Malinowitz (1995) complains:

> Over-represented by prestigious academic institutions, drawing on closed-circuit calls for papers, using a post-structuralist vocabulary that unabridged dictionaries haven't yet caught up with, heavily inter-referential and overwhelmingly white, the queer theorist network often resembles a social club open only to residents of a neighborhood most of us can't afford to live in (p.12).

According to Jagose (1996), another common objection to the recent queering of lesbian and gay identities focuses on political efficacy: to question the self-evident status of identity (so the argument goes) may well be explicable in intellectual terms but is indefensible because it encourages apolitical quietism. Often conceptualized as a 'gay generation gap' is the expressed objection that comes from those who cannot accept a once pejorative term as a positive self-description (Read, 1993). The reluctance of certain gay men and lesbians to identify themselves unequivocally as queer demonstrates that the categories are not synonymous (Jagose, 1996). Sedgwick observes that "there are some lesbians and gays who could never count as queer, and other people who vibrate to the chord of queer without having much same-sex eroticism or without routing their same-sex eroticism through the identity labels lesbian or gay."

Jagose notes:

> Queer's impact on identity politics has yet to be determined. It is probable that identity politics will not disappear under the influence of queer but become more nuanced, less sure of itself, and more attuned to those multiple compromises and pragmatic effects that characterize any mobilization of identity. Although frequently described as aggressive, queer is also tentative. It remains suspicious of homogenous identity categories and totalizing explanatory narratives necessarily limits its own claims. Queer's principal achievement is to draw attention to the assumptions that – intentionally or otherwise – are inherent in the mobilization of any identity category, including itself (p.47).

Mental Health and Queer Theory

To mental health professionals, queer theory and its discourses on the philosophical politics of identity are clinically relevant for a number of reasons. Foremost, because many gay and lesbian patients are increasingly familiar with the subject and are eager to discuss their lives and histories, using the rather unique vocabulary of queer theorists; secondly, because the traditional Western mental health formulations on sexual identity are decidedly bourgeois and grounded in a middle class perspective that fails many, especially those not from an American or Western European middle class; and lastly, because queer theory questions not just sexual identity but the process by which one acquires all the multifarious identities that coalesce to form a stable (and sometimes unstable) self that is fluid over time and dependent upon and related to one's place in history (Carroll, 1996). Queer theory offers

a complex view of non-heterosexuality without legislating its future. This larger philosophical perspective on non-heterosexual behavior and identity can offer a framework for demystifying sexual reorientation efforts.

Chapter 14: Homosexual Identity Development

The fluid versus static nature of homosexual and non-heterosexual identity and its relationship to sexual orientation is a recurring core theme in the debate over sexual reorientation. The use of the concept of 'homosexual identity' to refer to an aspect of homosexual functioning spans more than three decades. Cass (1984/1985) was one of the first to examine the popular writings of the late 1960s and 1970s through a scientific and philosophic lens. She postulates a number of factors that might account for the development of widespread interest in homosexual identity and formulates a scheme for identity acquisition:

- A change in perspective, apparent since the nineteenth century, from homosexual-as-object to homosexual-as-person.
- The gradual abandonment during the 1960s of the notion of collectivity and its replacement with the ideology of the individual, which emphasized the rights of individuals, free expression, self-fulfillment, and social tolerance.
- The increasing emphasis on social psychology and sociology in the humanistic approach to the individual.

Defining Homosexual Identity

An accepted standard of the concept of homosexual identity remains elusive. As Cass noted in 1985, there continues to be a very noticeable, almost universal lack of definition of the term 'identity' as it relates to the homosexual. A variety of diverse meanings can be inferred from the literature: 1) defining oneself as gay, 2) a sense of self as gay, 3) image of self as homosexual, 4) the way a homosexual person *is*, and 5) consistent behavior in relation to homosexual-related activity. 'Sexual-identity' and 'self-identity' are often used as explanations of homosexual identity. The notion of self, as in self-definition, self-concepts, and self-image, is often intricately bound to the idea of identity (Dank, 1972, 1971; Loewenstein, 1980; Weeks, 1980).

> In the absence of a definition for 'self', defining identity in these terms is of limited value. There are a number of idiosyncratic definitions for identity in the literature, however. Most authors can subscribe to the idea that identity is: " ... the answer to the questions: 'Who am I?' and 'Where do I belong?' " (Warren, 1981, p.10).

General Conceptions of Identity

Cass notes that when homosexual identity is considered from the perspective of human identity, interesting questions emerge. Can homosexual identity be presented as a construct similar to that described in the general literature as a person's overall identity? Is homosexual identity essentially similar to or different than ethnic, occupational, or status identities? Can one assume that homosexual identity and heterosexual identity are structurally alike? To what degree is homosexual identity time- and space-specific? What effects do particular sociological, psychological, political or economic conditions have upon the nature of homosexual identity?

Berger and Luckman (1966) assert that "theories about identity are always embedded in the more comprehensive theories about reality (p.26)." Cass worries that in homosexual literature theorists have given little attention to the assumptions that form the underlying base for their views on homosexual identity. Wegner, Vallacher (1986) and Riebel (1982) worry that there are researchers who fail to recognize the degree to which their work is based on personal beliefs about self. Any understanding of reality reflects past experiences, present social and psychological functioning and future aspirations, all of which are easily and subtly incorporated into research, either intentionally or unintentionally (Cass, 1985).

Identity and Self-Concept

In homosexual literature, the description of the relationship between identity and self takes one of three forms, holding either that the terms are interchangeable, that they are distinct and separate or that identity refers to a component of the self. Maslow (1968) noted, with reference to the concepts of 'identity' and 'self' that:

> ... partly, identity is whatever we say it is ... it means something different for various therapists, for sociologists, for self-psychologists, for child psychologists, etc., even though for all these people there is also some similarity or overlap of meaning (p.32).

Schafer (1973) believes that the only way to deal with the diffuse, multi-purpose uses of the terms 'self' and 'identity' is to "decide on the basis of the situation and the verbal context in which the word 'self' or 'identity' is being used at the moment, which aspect of a person is being pointed at." Cass found these approaches to be problematic for both scientists and researchers.

Homosexual Identity - Theory

Rosenberg defines 'self-concept' as the totality of the individual's thoughts and feelings referring to self as object. It includes all one's self-perceptions or self-attitudes, and the affective component attached to them, as well as self-perceptions of how one wishes to be.

Identity refers to organized sets of self-perceptions and the related feelings held by an individual about self with regard to some social category (Cass, 1985). It is said to represent the synthesis of one's own self-perceptions with views of the 'self' as they are perceived to be held by others. When self-perceptions and imagined other's views of self are in accord, identity may be said to have developed (Cass, 1985).

Homosexual identity is said to evolve out of a clustering of self-images linked together by the individual's idiosyncratic understanding of what characterizes someone as 'a homosexual' (Cass, 1985).

Carroll believes: that

> This understanding develops from the integration of the individual's unique interpretation of socially prescribed notions and self-developed formulations. Early stages of homosexual identity development usually involve cognitive processing of self-information against a symbolically held image of the 'generalized other'. Development of a fully integrated identity, however, requires more direct communication with others. Ultimately, this includes the presentation of a homosexual self-image to both homosexual and heterosexual others. When presentation is to one but not the other of these groups, homosexual identity cannot evolve completely. Commonly, the homosexual self-image is withheld from non-homosexual people and a heterosexual role adopted. A fully developed sense of self as 'a homosexual' requires accord between self-perception and imagined views of self held by all others constituting the individual's social predictable behavioral patterns. Stability is created through the constancy experienced in interaction with others. The individual strives to maintain cognitive and behavioral consistency, which in turn serves to reinforce the way others are believed to see the self. (p.26)

Both self-concept and identity are essential to an understanding of 'homosexual identity' (Cass, 1985). For example, the statements 'I am a guilt ridden homosexual' and 'I am a proud homosexual' both reflect some degree of identity development ('I am homosexual') (Cass, 1985). It is clear that there is no such thing as a single 'homosexual identity'. Many have noted that the nature of homosexual identity may vary from person to person, from situation to situation, and from period to period. Much has been written about the difference between self-image, 'I am a person who relates sexually to others of the same sex', (self-conception)

and 'I am a homosexual' (identity). Homosexual literature on identity alludes to both personal and social identity (Carroll, 1996).

A significant amount of psychological literature has been dedicated to identity as a cognitive construct. Cass recommends the terms 'presented identity', 'perceived identity', and 'self-identity' as solutions to the inherent conceptual problems:

> Presented identity refers to that picture of self presented to others with regard to a specific socially defined category, that is, the identity that a person wants others to believe one holds about self. Presented identity is closely linked with ideal components of self-identity. Perceived identity refers to that image held by another about self with regard to a specific social category. Such an image will develop out of a synthesis of the meaning others put on our behavior (presented identity) together with perceptions already held about us (p.42).

Cass (1984) was one of the first mental health writers to direct attention away from a discussion of the social identity and origins of the homosexual and towards the personal, cognitive aspects of homosexual identity development. Cass (1985) emphasizes that the individual's own perceptions of the world, rather than the world itself, are critical to the issue of identity.

Homosexual Identity as Childhood Outcome

The medical and mental health professionals have long promoted the idea that homosexual identity arises from childhood developmental processes. Proponents of these theories work either within an ego identity framework (Gundlach & Riess, 1968; Pattison, 1989; Weis & Dain, 1979) or a sexual identity framework (Green, 1974; Hoffman, 1968; Whitam, 1977).

Ego psychology, from which ego identity arose, is a derivative of psychoanalysis. Most ego identity theorists equate homosexual identity with ego identity (Carroll, 1996). Erikson (1959,1968) proposed the term 'ego identity' as the psychosocial integration of the individual that normally takes place in adolescence or early adulthood. Erikson (1959) clearly distinguishes ego identity from self-identity, which he defines as that which emerges from the integration of the individual's self-images (self representations) with role images (perceptions of social positions held).

Green's model for gender identity (1974) forms the basis of most of the models associated with the 'sexual identity' theorists. These dwell on explanations of sexual preference or orientation centered on early childhood development. These theorists generate significant

confusion between the behavioral and cognitive aspects of homosexuality and labor over the timing of identity development (childhood, adolescence, or adulthood) (Carroll, 1996). Plummer proposes a synthesis of both approaches, but, according to Cass, comes close to irreparably mixing behavioral and cognitive concepts. Cass (1986) emphasizes that the content and structure of gay identity change over time as the individual moves from childhood to adulthood, as well as from one period of adult life to another. The nineteenth century medical model classified homosexuals as sexual perverts (Boswell, 1980; Foucault, 1978).

> Psychoanalytic theory arose from this model and presented a theoretical conception of human development that likened identity development (the satisfactory integration of id, ego, and superego) with sexual identity. Accordingly, the development of homosexuality in adolescence and adulthood is seen as a fixation at the Oedipal stage of sexual identity development. Psychoanalytic theory therefore clearly links homosexuality with sexual identity. However, it is also clear that there are components of gay identity that are non-sexual (Carroll, 1996, p.56).

Cass' Six Stages of Gay Identity Development

Cass' (1985) proposal for a new model for homosexual identity development was born from dissatisfaction with the state of homosexual identity theory in the late 1970s. This model has been widely accepted throughout the mental health community, and is one of the core foundations upon which many of the 'gay affirming' therapies are based (Carroll, 1996).

In widespread use for fifteen years, generations of mental health providers have been trained (either directly or indirectly) to use this model in formulating treatments for homosexuals. The widespread and often uncritical application of such a model is problematic and not without consequences (Carroll, 1996).

Cass (1986) begins by stating her intention to explore the process by which a person acquires the identity of 'homosexual' as a relevant aspect of self. Her model has six stages of development through which all individuals move to acquire a 'fully integrated' homosexual identity. At each stage 'identity foreclosure' is possible ('the person may choose not to develop any further'). She describes the 'interactionist' situation that contrasts private and public aspects of identity. Growth from stage to stage is driven by the incongruity between aspects of private and public identity felt by the individual. Initially, the person in question assumes that everyone will self-label as heterosexual. With time, the label 'homosexual'

replaces 'heterosexual', resulting in a stable homosexual identity with the minimum amount of inconsistency between self and society (Carroll, 1996).

Stage 1: Identity Confusion

Cass (1979) assumes that, because of pressures from society, everyone is initially heterosexual. Subsequently, the realization that feelings, thoughts, or behaviors can be defined as homosexual "present an incongruent element into a previously stable situation" (Cass, 1979). For the first time, the subject asks: 'Who am I? Am I a homosexual?'

Stage 2: Identity Comparison

With this stage comes 'the first tentative commitment to a homosexual self', manifested as the recognition of difference from the societal norm (Cass, 1979). Cass (1986) outlines three groups of people who tend to react this way: 1) those who feel that they have always been 'different' and come to use the term 'homosexual' as a way of verifying this difference, 2) those who have felt 'different' on the basis of their nonconformity to traditional heterosexual forms such as marriage, 3) those who find being different 'exciting'. She outlines four strategies that people use during this stage to reduce incongruence:

- Special case strategy - "If it were not for this special person, I would be heterosexual."
- Ambi-sexual strategy - "I could act heterosexual if I wanted to."
- Temporary identity strategy - "A homosexual identity is only temporarily applicable."
- Personal innocence strategy – "I cannot help it. I was born this way."

Stage 3: Identity Tolerance

At this stage, an individual declares: "I am probably a homosexual" and seeks additional contact with like-minded others. There is also an increased sense of 'not belonging' with heterosexual others (Cass, 1979).

Stage 4: Identity Acceptance

The gay subculture " ... now plays an increasingly important part in the individual's life and subsequently in the restructuring of an interpersonal environment" (Cass, 1979).

Stage 5: Identity Pride

In this stage the individual devalues the importance of heterosexual others and instead esteems the opinions of his homosexual peers (Carroll, 1996). The individual "not only accepts a homosexual identity but prefers it to a heterosexual one" (Cass, 1979, p.22). The disparity between the treatment of homosexuals and that of heterosexuals generates "feelings of anger born of frustration and alienation (p.23)." As a way of coping, the individual opts for increased disclosure of his homosexuality and 'comes out' to his straight peers and family (Cass, 1986).

Stage 6: Identity Synthesis

With this stage the dichotomy blurs between the heterosexual and homosexual worlds as the individual finds that some heterosexuals are supportive of an alternative lifestyle (Carroll, 1996). Anger diminishes because of a reduction of incongruence and " ... the gay identity, instead of being seen as the identity, is now given the status of being merely one aspect of self" (Cass, 1979, p.12).

Critique of Cass' Stages of Homosexual Identity Development

Cass specifically identifies that there are six stages through which *all* individuals pass. Weinberg makes a number of useful criticisms of her approach. Cass' primary assumption precludes consideration of the possibility that there may be other pathways to the same identity. It also presupposes a uniform development rate. Cass conceptualizes variation from the developmental schema as 'identity foreclosure' and implies that 'to waver from the single pathway' is immature, regressive, or fixated. Cass establishes a single 'starting point' from which everyone begins as 'heterosexual' and an ultimate goal of a stable homosexual identity as the final 'objective.'. Her schema fails to acknowledge the 'inherent flexibility of human

beings', an example of which is the individual who begins as a heterosexual, becomes a homosexual and then later returns to heterosexuality (Cass, 1985).

Carroll notes that:

> ... the way in which Cass uses the term 'homosexual' in the presentation of her stages of development is notable for a lack of definition or any exploration of its meaning. In other works by the same author, she makes clear her belief that 'homosexual' is a term in desperate need of definition, resulting in a situation whereby, for the last thirty years, mental health providers have been free to apply any meaning they choose for the terms 'homosexual' and 'heterosexual' and then organize it according to Cass' stages. The use of a hetero/homo split embodies an unspoken assertion that there are no other major organizing categories and that categories such as race, class and gender have little or no impact on how individuals organize their own sexual identity. Cass describes an original stability of identity that assumes alignment with other cultural norms, so that confusion only exists on a 'hetero/homo' sexual axis (p.86).

Cass makes no mention of the use of the hetero/homo binarism as a predominantly middle class, male distinction that has a particular ideological agenda - one which is described by Carroll as the quest to create an individual identity recognized within society as a male middle class objective. Cass presents a hetero/homo split which begins with stability and leads to instability and is representative of white middle class male anxiety, failing as an indicator valid for 'all individuals' (Cass, 1986). Carroll is interested in comparing Cass' hypothetical gay male, who seems to become gay solely because of his internal homoerotic desire, to the 'political lesbian', who first identifies as a radical feminist and then makes a conscious choice to be a lesbian for political and ideological purposes.

Carroll, irrevocably classist, places the emphasis on comparison in the second stage identified by Cass conflates the many points of multiple comparisons that occur. This comparative process is clearly idiosyncratic and multifarious with influences from race, class, gender, religion, and place in time. Carroll notes that lower class Hispanic culture in America often insists on a very rigid split between genders. Many young gay men in this culture identify same sex desire with gender inversion and assume a feminine gender role. The nascent gay from such a background will feel forced to emphasize behavior that reinforces the opposite gender as well as same-sex attraction.

Cass' stage two also presupposes a salient core of homosexual behavior or desire with which the term 'homosexual' fits with some resonance (Carroll, 1996). She dismisses the

frequency with which the categories of homosexual or heterosexual fail to be an exact fit for the individual, pre-empts other interpretations and disavows incongruent behavior as well as reinterpreting previous behavior using a homosexual context. Carroll describes how, once an individual assumes the label 'homosexual', a case must be made to support the identity from past behavior. Evidence in support of the label will probably be highlighted and that which fails to support it will be eliminated or suppressed. The individual wrought with cognitive dissonance will effectively rewrite personal history to give him or herself a homosexual past, regardless of whether or not that was actually the case. The same individual is also likely to construct a future in support of the label. Much has been written about heterosexuals who must disavow homosexual desire so completely that they eradicate any indication of its original presence.

The stage of identity tolerance is described as a time of increased confusion and excitement, with marked differences between the experiences of urban and rural people. In large cities, the gay and lesbian world is a highly varied, pluralistic one containing many subcultures with divergent mores and codes (Carroll, 1996). In rural areas, gay socialization may be highly restricted and fail dramatically to reflect the individual's tastes, be they cultural, religious, racial, gender, political, or economic.

The stage of identity acceptance is marked by increased incongruity between a private life of 'acceptance' and 'the closet'. Cass fails to fully explore the complexity of the gay environment for those who are neither white nor middle class. The debate on sexual reorientation is often guilty of the same failings. Much has been written of the unique experiences of 'multiple minorities' individuals (Afro-American lesbians, HIV positive gay Latin-American men, inter-sexed native Americans, post-op trans-gendered pacific islander lesbians, etc.) Among the 'multiple minorities' writers there is wide consensus regarding the lack of applicability of models based on white middle class American values and culture.

Economic class differences, as well as race and gender issues, provide additional levels of complexity. Such complexities often escape public and professional analysis as they cloud the political agenda. Carroll notes that among lower class urban, often homeless youth involved in prostitution, many identify as 'straight' or heterosexual, although all sexual contact is with the same sex, independent of the presence of an exchange of money.

'Coming out' originally referred to the process of coming out within the gay community and contained no reference to the 'straight' community. According to Carroll, identity pride as a component of a middle class egalitarian model parallels the rise of the middle class in the course of the last century. A homosexual model that imitates many of the same structures of heterosexual life, such as marriage (long term monogamous relationships) also places an emphasis on coming out to the straight world. This has multiple political, religious, and cultural implications associated with the assertion 'We are just like you, just different'. 'Coming out' and 'outing' has been a very politically powerful tool for cultural change in the West.

Within the gay community there is significant pressure for its members to get out of the 'closet', as doing so generates political and social power to fuel change. Cass' model views the process of 'coming out' as a developmental step, yet neglects the impact of local gay culture and subcultures (1985). 'Coming out' is a very different process in San Francisco than in Cardiff, Dublin, Toronto, or Dallas.

Cass (1986) also neglects the complexity associated with 'coming out'. Much has been written about unilateral or partial outings (at work but not with family, with family but not at school). Partial outings are often viewed as foreclosure or a stalling of identity development, but may in reality reflect specific environmental situations or other identity attachments not considered by Cass' model and the therapists that depend on it. The teacher or sports coach may jeopardize a career by coming out of the closet before tenure is obtained. It is not uncommon for Hispanics to live a fully obvious gay life-style, yet never use the terms gay, lesbian, or homosexual with their families, out of respect for their elders, Catholicism, and culture.

Identity pride and 'coming out' may be profoundly complicated by HIV and AIDS. Carroll describes the existence of an unspoken code of appropriate behavior amongst HIV positive and negative men that is only now finding representation in the literature. Often, these codes of behavior remain difficult to explore because they run counter to politically correct messages about sex and safety (Carroll, 1996).

Cass (1979) notes that as gay pride develops, many gays discover for the first time a deeply seated anger against society and governments for their discrimination against gays. Carroll postulates that for many this anger originates from the lie of living within a sexist,

capitalistic society. He believes that it has the transformative potential for uniting women's causes with gay male and lesbian causes as well as those of other minorities (racial and religious). This anger may cause some to drop out of traditional society altogether and embrace a marginalized life-style as part of a broader political statement against capitalism and the tyranny of gender. Others (often white, conservative middle class males) may encapsulate the anger and aim it exclusively at those engaged in same sex discrimination.

The final stage of identity synthesis reveals the normative ideal. According to Cass, the ideal homosexual is not too angry, has an acceptance of some heterosexuals as such, and has returned the major focus to the larger existential issues of life, which are outside the purview, *per se*, of a gay identity (Carroll, 1996). Carroll views this as a middle class model of appropriate social behavior which seeks to contain the waywardness of the angry, militant homosexual within the traditional boundaries of private/public, individual/social, and family/society. The good homosexual is one who is angry, but not too angry, separatist, but not too separatist, rambunctious, but hopefully able to settle into a long term, monogamous relationship.

Cass (1986) presents a normative ideal in which gay identity recedes to the background and mainstream middle class identifications (in which class and race are bracketed out) supersede the minority identifications of the gay community.

Homophobia and the Normative Ideal

Cass (1979) describes the beginnings of a negative self-hating identity in Stage One as the idea of a homosexual self first arises. "Such an identity is internalized during subsequent stages of gay identity consolidation" (Cass, 1979). However, Stage Five: Identity Pride is said to mitigate this self-hating identity as a new sense of pride is internalized through "voraciously consuming gay literature and culture" (Cass, 1979). Ultimately, such a strategy is only partially successful. Given societal attitudes about homosexuality "it is probably impossible ... to achieve a homosexual defining matrix that is totally (cognitively and affectively) congruent. It is possible, however, for incongruence to be reduced to a level that is both tolerable and manageable" (Cass, 1979).

Carroll identifies the dilemma of Cass' middle class view of homosexuality as the contingent nature of homosexual identity and its relationship to heterosexuality and the middle class. Carroll notes:

> Heterosexuality and homosexuality are enforced categories that only recently have been mapped onto gender. They are not inevitable organizations of 'natural human kinds', but socially created categories that represent specific middle class aims. Such categories are forcibly and often violently enforced upon all boys at a young age through repudiation and vilification of specific thoughts, emotions, and behaviors, which are then carried as a 'negative or self-hating' identity by all straight and gay people alike. The acceptance of the term 'homosexual' is the acceptance of the middle class organization of sexual behavior as organized by the hetero/homo binarism. Thus, to accept homosexuality is also to accept heterosexuality, while exclusive heterosexuality is built upon the vilification and suppression of homosexuality (p.192).

Cass' model of development presents a positive gay identity built upon the category of homosexual, which contains the acceptance of the category heterosexual and, by consequence, the vilification of homosexuality with the culture (Carroll, 1996). Internalized homophobia is the double bind of the gay positive identity. The model presents the ideal homosexual, who, through acceptance of his marginalized and second-class status, is made 'tolerable and manageable' to culture at large (Carroll, 1996).

Summary of Criticism of Cass' Model

Carroll points out the presuppositions of a liberal, late 1970's, middle class gay agenda in Cass' developmental theory. The relevance to a twenty-first century view of non-heterosexuality lies in the realization of just how little one can rely on biological, scientific, or culturally fixed positions of the subject matter of gender identity in the context of tackling the ethical issues or reorientation. The contrast between the view of our modern era, Western civilizations and that of classical Greece provides some perspective for the re-evaluation of those beliefs often held to be self evident.

The value of a critical review of Cass' model is its provision of theoretical context for gay affirming therapies and the exploration of the impact of Cass' work on clinicians who continue to use her schema and the assumptions underlying it in the provision of gay affirming therapies (Carroll, 1996). Likewise, Cass' model offers a formula for the social and personal construction of a homosexual identity and provides some insights into an

understanding of the popularity of conversion and reparative therapies aimed at deconstructing the same. The Western obsession with sexual orientation can be put in a clinical perspective. Bioethics offers the hope for a "point on the horizon" from which one can navigate these shifting clinical waters.

Section V: Bioethics

With history, etiology, stakeholder position and theory review behind us it is appropriate now to view the broad landscape of issues relevant to the debate on sexual reorientation through the panoramic lens of bioethics. As noted in the introduction, whereas medical ethics is focused on the relationship between patient and provider, bioethics draws from a larger arena that includes philosophy as well as the social, psychological and political sciences. The various chapters in this section look at issues raised by the stakeholders in this debate.

Chapter 15: Bioethics and Substituted Judgment

Any time the medical system is given the right to make decisions on behalf of others, it is presumed to be with their best interests in mind. Likewise, there is a universal expectation that clinical decisions involving children, infants, and the unborn are made on their behalf by competent others. The others involved in decision making on behalf of children, infants, and the unborn are usually parents, but often also includes schools, public policy makers, health providers and others in society with a stake in the decision's outcome. Clinical decisions to be made on behalf of adolescents and incompetent adults can also present complex problems. Parties on both sides of the ethical debate surrounding sexual reorientation have complained bitterly about who and how these decisions are made when the decision does not go their way. Substituted judgment is the process by which such decisions get made.

Substituted judgment addresses the issues of competence, autonomy, and informed consent, which are frequently raised with sexual reorientation interventions and lie at the core of many bioethical conflicts. Substituted judgment can be summarized as follows*: I/we know better than you/them.* In general, parents are presumed to know better than their children or dependent adolescents. In general, competent adult patients are presumed to know better than their health providers once adequately informed. In general, individual clinicians are presumed to know better than policy-makers, governmental agencies, and special interest groups. Substituted judgment speaks to the locus of ethical decision-making. Locations for these decisions may include policy makers, health providers, health consumers, religions, minority political activists, health service payers, parents, schools, and communities.

Parents and their Offspring

Public policy in most Western societies is to emphasize and reinforce the role and responsibility of parents for making informed decisions about the lives of their dependent offspring. These begin prior to conception with the choice of mate and birth control options and extend until the offspring is competent and independent. There are a number of non-controversial situations in which public policy advocates intervention on behalf of the child, such as prohibitions against third trimester abortions; interrupting and preventing childhood physical or sexual abuse; mandating some minimum of education for school age children; prohibiting the abuses of child labor. Public policies that countermand a parent's 'rights' can

also be more controversial, including policies regarding genetic testing and fertility interventions, parental decisions to withhold lifesaving medical interventions on religious grounds, and parental control over teenage access to birth control, abortion, sexual reorientation, and gay-affirming therapies.

The American Academy of Pediatrics and the American Academy of Family Physicians have both issued policy statements against the provision of sexual reorientation interventions for adolescents, although the provision of therapy for gender identity disorders in children and adolescents remains unaddressed.

Could policy makers believe that parents' have less ability to make informed decisions about the sexual orientation of their offspring than about other medical interventions? It is certainly conceivable that religious beliefs which are strongly held by parents and less so by their dependent adolescents may be a source of family discord. Historically, parental shame can play a significant role in how decisions are made about sexual issues with regard to dependent adolescents (birth control, abortion, sexual reorientation).

Public policy has been to intervene when parental and adolescent decisions are in conflict and there are long-term consequences to the outcomes of these decisions. Many jurisdictions are willing to grant the adolescent decision-making powers regarding certain issues of sexuality prior to granting the adolescent full, autonomous independence from the parents (Rodman et al, 1984). For example, in many areas, a dependent adolescent can secure an abortion without parental consent while they cannot have their wisdom teeth or their appendix removed without parental consent. There is no consensus on whether or until when it is appropriate for a parent to deny homosexual teens access to gay-affirming therapy. There is also no consensus on if or until when a parent should be allowed to attempt to change their offspring's sexual orientation.

The position of the gay and lesbian community is that the only appropriate response from a parent is to accept and support an offspring's adjustment to their sexual orientation. On the other hand, many religious groups maintain that a parent is obliged to do everything possible to facilitate the development of a normal, healthy adult heterosexual identity in their offspring. Bioethics can help to resolve conflicts between parental goals and professional policy as well as conflicts between parental goals and adolescent goals.

Social science and public policy research have suggested that after the age of 15 most teens are competent to make informed decisions about sexual issues (Rodman et al, 1984). This research was based on a study of adolescents' ability to fully participate in the informed consent process involving disease prevention, birth control, and abortion. The issues raised in sexual reorientation and gay-affirming therapies for adolescents share many of the same fundamental questions poised by adolescent heterosexuality: How will the decisions I make about my behavior influence who I am and who I will become? What are the personal, family, and social consequences of my decisions? What are my values? How do I reconcile my values with those of my religion, my family, my culture, and my peer group? This data substantiates the inclusion of adolescents in bioethical debate and formulation.

Providers and Policy Makers

Modern medicine has tended to move away from physician paternalism towards a view of the patient and provider as partners in health care. The physician or health care provider is expected to be a technical resource for clinical information and skill and the patient is expected to make health care decisions on the basis of personal needs, values, and goals.

The basic concept of medio-legal informed consent is flawed. During the provision of health care there are often factors beyond the patients' control interfering with their ability are less able to make fully informed decisions. Pain, fear, shame, anxiety, or the physical and mental consequences of a medical or social condition naturally threaten usual judgment. During such times, the clinical provider must resort to his or her own knowledge of how the patient would decide, or to consult previously written advanced directives or pre-identified decision makers (medical power of attorney) or work to facilitate patient's own decision making. Community standards influence this sphere, as does the advice of an ethics committee. There are also situations in which public policy removes the responsibility of decision-making from the clinician or the patient. For example, in many areas a physician is obligated by law to report any suspicion of child abuse or neglect for further investigation. In other situations, professional policy makers provide guidelines and policy statements that do not carry any force of law but burden the provider with increased financial risk for clinical practice beyond 'established guidelines' or 'community standards of care'. These situations clearly demonstrate public or professional concern surrounding the quality of the decisions

that providers make. Also of concern is the provider's religious or political beliefs and how those impact the treatment recommendations. There is controversy, also about exactly why this explosion of professional policy making and guideline issuing regarding sexual reorientation has occurred in mental health. It has been alleged that the gay and lesbian communities are primarily behind the process (NARTH, 1991), which has called into question the appropriateness of allowing gay and lesbian politics to directly or indirectly dictate professional practice in mental health. There are additional suggestions that this population (struggling with ambivalence about sexual orientation) is vulnerable and in need of additional protection. The question really seems to be whose judgment is the most trustworthy? Patient, parent, clinician, professional organization, church, or socio-political movement?

There is no doubt that the answer sought, is not simple and will not be consistently predictable across all clinical scenarios. Because of the complexity involved, it is reasonable to be suspicious when religions, political groups, or policy-makers promote one all-inclusive broad sweeping solution for all such clinical questions. Many in the health professions look specifically to bioethics (instead of health policy makers) to formulate a path to a resolution for these complex questions.

Chapter 16: Bioethics and Biotechnology

Stakeholders have expressed concern about research focused on the origins of sexual orientation and the risk of future misuses of biotechnology for genetic screening and genetic manipulation of sexuality. A future in which sexual reorientation interventions become more efficacious could see a return of a generalized widespread belief that sexual orientation is a matter of choice for everyone. Improved efficacy of sexual reorientation interventions would, predictably, increase pressure for non-heterosexuals to choose to change. These concerns appear throughout discussions of the future of sexual orientation research and reorientation interventions.

The dawn of the twenty-first century has witnessed the complete mapping of the human genome. The first 'test-tube' baby is an adolescent and human cloning is conceptually as well as technically feasible. The explosion of biomedical technology is both wondrous and frightening. Prenatal counseling and genetic screening are considered par for the course in Western societies. Pregnancies are routinely screened for common congenital disorders such as neural tube defects (spina bifida, anencephaly), chromosomal disorders such as trisomy 21 (Down's syndrome), Klinefelter's and Turner's syndromes, and familial disorders such as sickle cell and cystic fibrosis.

Bioethics as described by Kunkler (2001) is the study of value judgments relating to human conduct in the areas of biology and medicine. Advances in biotechnology are quickly surpassing not only existing legal and ethical guidelines that govern research, but also our understanding of its moral, social and religious implications. As a result, substantial pressure has been put on both governments and professional organizations to establish ground rules.

The protracted Bush administration deliberations of 2001 over the use of U.S. federal money to fund embryonic stem cell research or whether to even permit such inquiry at all is evidence of the complexity of these issues. President Bush came out against human cloning, stating: "The administration supports a ban on the cloning of human beings by somatic cell nuclear transfer." However, the administration does " ... approve of the development of cell and tissue-based therapies based on research involving the use of nuclear transfer or other cloning techniques to produce molecules, DNA, cells other than human embryos, tissues, organs, plants and animals." U.S. Congress banned the use of federal money for stem cell research involving the destruction of a human embryo, but the National Institute of Health

(U.S.A.) has sidestepped this law by supporting stem cell researchers so long as they themselves did not extract the cells from the embryo. Other concerns unleashed by the advances in our understanding of the human genetic blueprint include:

- The ethics of human cloning, particularly when the technology is so incompletely understood.
- The desirability of allowing food products derived from cloned animals to be sold in U.S. markets before the full public health risks, if any, have been examined.
- The ethical dilemmas surrounding genetic screening and directed reproduction based on the social utility of desired characteristics (ex: heterosexism).
- The dangers associated with xenotransplantation.

The ways in which we conceive ideas such as evolution and identity are being changed by new genetic breakthroughs. The debate even threatens to move beyond the issues of stem cell research before important questions are fully answered. The techniques of somatic gene transfer, in which adult cells in the body are modified in order to cure disease without changing the basic substance of the genes passed on, and germline genetic engineering, banned in many countries because of its potential to allow the manipulation of fundamental characteristics such as personality and appearance, will add to an already confused public debate (Kunkler, 2001).

James Watson, the co-discoverer of DNA, and the former head of the National Institute of Health, and a Nobel laureate, asks: "If we could make better human beings by knowing how to add genes, why shouldn't we? (p.430)" Others, such as Nobel laureate genetics professor Francois Jacob, express concern over science that has progressed to "where the point is no longer to heal someone but to modify him, to mold him." He goes on to say "on no account is it for scientists to decide questions of this magnitude" (Kunkler, 2001, p.2). Bioethics and medical ethics, not science, are the setting for these debates.

Stem Cell Research

Because of its foreboding future impact, stem cell research strongly relates to bioethical considerations of sexuality. Should life be preserved at the expense of other life or is it wrong not to do everything in our power to find cures for debilitating diseases? Does the fact that many of these embryos, byproducts of fertility clinics' efforts to help couples conceive, will

probably be destroyed anyway alter the equation or is it just splitting moral hairs to allow this form of 'harvesting' while prohibiting the creation of an embryo for the express purpose of destroying it, no matter what research purposes will be served? Do the answers change when the focus shifts from 'finding cures for debilitating diseases' to 'gaining control over and predicting sexual orientation and behavior'?

Opponents of embryonic stem cell research point to the uncertainty of the benefits to be derived and believe they do not mitigate the moral repercussions of using human embryos for research (Kunkler, 2001). They also point to the promise of adult stem cell research, noting that the level of private funding for this field far surpasses that of embryonic stem cell research, resulting in the faster development of practical applications derived from their study. Research has also suggested that adult stem cells may be more versatile than previously thought. At any rate, claim opponents of embryonic stem cell research, even if adult stem cells are not as potent as embryonic stem cells, they will suffice for most practical applications. Also, the problem of tissue rejection may be more easily solved with therapies derived from adult stem cells, because the transplanted cells would carry the patient's own genetic imprint (Kunkler, 2001).

Supporters of embryonic stem cell research point to the greater flexibility of stem cells at their most undifferentiated state. They also note that little would be known about adult-derived stem cells without the benefit of research on embryonic stem cells. Most researchers in the field dismiss the idea that adult stem cells offer an easy way out. For example, finding the blood-forming stem cells in bone marrow is proving to be an enormous challenge (Kunkler, 2001). Many caution against making exaggerated statements about the drawbacks or benefits of either kind of research and stress that, since so little is yet known about how these cells develop into specific tissue, research on both types of cells is necessary. The Royal Society (2001) has considered the relative merits of research on adult and embryonic stem cells and concluded that conducting research on both types is essential, stating that: "adult and embryonic stem cell research are not alternative and both must be pursued. In all likelihood each will yield distinctive therapeutic benefits." They further note that adult stem cells are "small in number and often hard to access ... an important issue that needs to be acknowledged is the fact that, with very few exceptions like bone marrow, adult stem cells may only be obtained from organs of very recently deceased individuals."

Human Cloning

Human cloning also promises impact upon the future of sexuality. It has generated significant public debate since Dolly (the sheep) was cloned in Scotland. Discussions have included cloning implications tied to issues of sexuality and sexual orientation.

> To create a clone, researchers transfer the DNA from one cell into an egg cell that has been emptied of its own DNA, enabling the egg to 'reset' the gene expression of the injected genetic material. From there it grows into an embryo and, eventually, into a genetic duplicate of the donor. In one variant known as 'therapeutic cloning', a cell from a patient is cloned and then allowed to divide until it reaches a pre-embryonic stage, from which the stem cells that could be developed and used to replace damaged tissue without the risk of rejection by the patient's immune system can be extracted. While nearly all of those doing research of this kind are careful never to work with embryos older than 14 days, critics maintain that the cells theoretically represent a potential for human life.
>
> Many ethicists believe that no company should proceed with this kind of work, whether cloning with the intent of harvesting stem cells or of allowing the embryo to develop to term, until there is some kind of public consensus. Despite ethical, technical, and legal concerns, some scientists are determined to forge ahead in their endeavors to clone a human being. Pro-cloning researchers claim that it may be easier to successfully clone people than other animals due to experience with growing human embryos in the laboratory for in-vitro fertilization. Others disagree vehemently, noting that the problems with cloning remain biological, not technical; the problem does not lie in getting embryos to survive in a Petri-dish, but rather, in the potential for unforeseen defects as the embryo develops.
>
> Interestingly, all the commotion may be for naught, at least in a legal sense. Biotech companies, desperate for patients, as well as some academics, are beginning to ask: "Can the government really stop me from cloning myself?" Although the bills recently passed by the U.S. Congress would seem to settle the matter, some legal scholars say that attempts to prevent scientists from going ahead with human cloning, whether by the U.S. FDA or by the U.S. Congress, may have no basis in law (Kunkler, 2001, p.3).

For the gay, lesbian and queer communities there are two issues. Cloning as a route to conception speaks to traditional feminist thought about a 'woman's right' (and that of men) to control their reproductive choices. If and when conceptive cloning becomes readily available, research into sexual orientation outcomes will potentially provide a unique complement to the data already available on identical twins *vis a vis* environmental impact. Cloning for stem cells has the potential to advance research into the origins of sexual orientation and, perhaps, to offer biotechnologic interventions to change orientation, if for example an immunologic or

pheromone receptor hypothesis were to be proven correct. As we have seen, this could be a welcome or threatening prospect, depending on one's point of view.

Genetic Screening for Desired Traits

Many dream of screening out gayness as a genetic disorder. Should genetic disorders come to be viewed in the same negative light as transmissible or contagious diseases revealed by genetic testing they might have their wish the lesbigay community fears. The U.S. Congress' Office of Technology Assessment (2001) defines genetic testing as "the use of specific assays to determine the genetic status of individuals already suspected to be at high risk for a particular inherited condition" (Kunkler, 2001, p.4). The National Academy of Sciences (U.S.) (2000) defines genetic screening as the "systematic search of populations for persons with latent, early, or asymptomatic disease." The danger of discrimination based on the contents of a person's genetic profile is only one of many issues with which bioethicists are grappling. Important questions about issues of privacy, self-determination, and intolerance also remain unanswered. Others are concerned that as a result of some kind of cost-benefit analysis, individuals may be forced to submit to testing, losing the option of *not* knowing about potential genetic defects; they may be compelled to disclose them to others, or to forgo having children, thereby reducing the long-term medical costs to society, 'in its best interest'. The fear is that this kind of thinking will result, in the words of one bioethicist, in a "new eugenics based not on undesirable characteristics but on cost saving" (Kunkler, 2001, p.4). The dangers of isolation and the potential loss of insurance, education, and job opportunities for persons diagnosed with incurable and costly disorders, as well as potential clinical uses and abuses of the new genetics, are all questions to be answered.

Ethicists point out the need for caution when discussing 'designer genetics'. They also point to the differences between definitely having a disease and merely being at risk for developing one. At present, the degree to which a person is at risk for a particular disease is impossible to tell in all but a few specific cases.

In a current real life clinical example reported by the British Broadcasting Corporation (Technology in the News, 1999), a couple bearing the genetic risk of hemophilia for 50% of their male offspring chose to use state of the art reproductive technology to ensure that they only produced female offspring. The process began with the collection of eggs and sperm

from the parents, test-tube fertilization and the production of 10 embryos. Once the embryos were at the 'eight cell' size, one cell was removed from each and genetically examined (the removal of one cell from an 'eight cell' embryo is known to be of little or no consequence to the eventual organism). Of the original 10 embryos, five were found to be male and were discarded because of the risk of hemophilia. The remaining 5 female embryos revealed one with an increased risk of developing breast cancer, one with an increased risk of developing colon cancer, and three with no increased risk for either disease. These last three were transferred to the mother's uterus and one normal female infant was subsequently delivered. Curiously, at the time of this procedure, there was the technology to differentiate the male and female embryos and identify genetic risks for colon and breast cancer but not to predict which of the male embryos were at risk for hemophilia and which were not.

If technology develops to the stage whereby procedures exist to predict a risk for breast cancer, colon cancer, and non-heterosexuality, the ethical questions will become even more complex: "Do I want a gay son or a straight daughter who is likely to need a mastectomy sometime before the age of 50?" The rights of the parents to control reproductive decision-making, balanced against the rights of the embryo and those of society at large create an extremely complicated scenario. Imagine the situation whereby feminist-lesbians have to weigh the 'right of a woman to choose' (reproductive freedom) against the rights of the gay, lesbian, and queer communities to pursue social equality and avoid future extinction by legislating against designer genetic screening for heterosexuality.

Attempting to predict the future evolution of reproductive biotechnology is beyond the scope of this thesis. However, it is reasonable to assume that advances will continue exponentially. My personal prediction is that sexual orientation will be discovered to be a multi-factorial process subject to variable genetic and environmental control. In other words, a variety of 'sexual orientations', behaviorally similar, will be discovered to have a range of genetic and environmental origins.

Opponents to research into the role of genetics in sexuality from within the gay, lesbian and queer communities emphasize that sexual orientation research is not value-neutral, questioning whether those who research sexual orientation can *ever* conduct their work in a value-neutral manner. Concern is also expressed about the prediction of sexual orientation in utero or in vitro, raising ethical implications surrounding the decision to destroy non-

heterosexual embryos or to abort non-heterosexual fetuses. It is potentially difficult to support legislation preventing such events while simultaneously supporting individual 'reproductive choice/freedom'. Feminist lesbians may find themselves in the position of having to choose between loyalty to women and loyalty to the non-heterosexual community. Alternatively, some gay and lesbian parents might eagerly embrace the opportunity to choose heterosexual offspring. Knowing at first hand the social injustice associated with non-heterosexuality, the decision is made on the basis of what is to their offsprings' advantage at the expense of what may be best for their sub-culture/community. Similarly, many non-heterosexuals believe that discovery of a biological process determining sexual orientation can only benefit the gay and lesbian community through normalizing non-heterosexuality, diminishing 'efforts to change orientation', and reducing the commonly held conservative belief that sexual orientation is chosen by people with diminished character, morality or values.

This chapter discloses in part the complicated issues surrounding the modern practice of genetic science. While proponents can point to hypothetical future benefits for millions who suffer from physically and socially debilitating states, opponents are deeply worried about the religious, ethical, and moral contradictions inherent in ending one potential life to benefit another or in manipulating and redefining the building blocks of human diversity, including sexual diversity. From an ethical standpoint both issues (right to life and right to sexual diversity) are important, in the context of this discussion, the implications for expanding versus narrowing sexual diversity is of primary focus.

Opponents to research into the biological origins and mechanism of sexual orientation from within the gay, lesbian, and queer camps are concerned about potential future impact of such research. Lesbigay opposition to stem cell research regarding origins of sexual orientation gives the lesbigay the very strange bedfellow of the Christian "right to lifer."

Chapter 17: Bioethics and Religion

Two major stakeholders in the debate on sexual reorientation interventions are conservative and fundamentalist Protestant churches actively invested in the business of sexual reorientation interventions and the devoutly religious non-lesbigay non-heterosexual who requests reorientation. Religious freedom and tolerance are highly valued principles in the healthcare systems of America and Western Europe and therefore any professional policy statements must accommodate diversity of religious beliefs and value systems.

A sizable group of non-heterosexuals, despite having been shamed and branded as guilty by the churches in which they were raised, seek to maintain positions as respected members of their congregations. Many experience their religious affiliations so intensely that they may perceive their sexuality and sexual orientation as being of secondary importance. Similarly, many heterosexuals with intense religious affiliations allow church doctrine to dictate their decisions and behaviors related to sexual issues (celibacy before marriage and after divorce, serial monogamy, access to divorce or annulment, etc.). For many unhappy, socially marginalized homosexuals, changing sexual orientation in lieu of abandoning their religion seems like a logical choice to make. In attempting to do so, many religious homosexuals turn to the Ex-Gay ministries or to the clinical reorientation intervention programs offered by some mental health professionals.

In contrast, many gays and lesbians describe chronic dissatisfaction with their religious upbringing. Haldeman describes an encounter with a gay man who believes that his church (Catholic) has, historically, been a powerful agent in the institutionalization of homophobia, and who maintains that until the church is willing to acknowledge him, he will stay away. The subject likened continued church membership on the part of lesbians and gays to the situation of the spouse or partner who remains in an abusive relationship (Haldeman, 1994).

Religion and mental health have long had a complicated, sometimes collaborative, and sometimes competitive relationship. It is clear that the interests of religion and mental health intersect significantly, providing parallel vectors of insight and guidance as individuals strive to achieve and sustain quality, meaningful, coherent, and morally consistent lives. The relationship is further complicated by the diversity of religious practice, and changes in doctrine and practice over time as well as by the evolving research and clinical practice of mental health. Ethical concerns arise as competing moral claims come into play.

Bioethics offers a congenial venue for adjudicating the competing, and sometimes contradictory, moral claims of religion, mental health, and lesbigay and queer communities. It offers insights and practical guidance on topics ranging from the care of individual patients to the development of social and professional policy.

Religion and Sexuality

Much of the social psychology of classical Freudian theory identifies group formation as being rooted in the control of sexuality and dyadic intimacy. The social and cultural history of sexuality is largely a religious one (Parrinder, 1980). The gay, lesbian, and queer communities have accused the transformational ministries and Ex-Gay movements of using 'coercive persuasion' (brainwashing) in their efforts to change sexual orientation (NARTH, 1991).

Brainwashing entered popular language during the cold-war era. Historically, it has been divided into two varieties. 'European brainwashing' describes the process for obtaining confessions of guilt from presumably innocent people (Somit, 1968). 'Chinese brainwashing' focuses upon efforts to change people's total ideological orientation, typically with group situations where many are solicited as volunteers (Somit, 1968). Many religious cults, sects, and churches employ a combination of shame and ritual that embodies many aspects of coercive persuasion.

Hood et al (1996) summarize the components involved in coercive persuasion:

- Total control and isolation. Persons are isolated (individually or in small groups), under the absolute control of authorities.
- Physical debilitation and exhaustion. Persons are physically exhausted and debilitated. Causes can include constant interrogation and/or continual prodding from peers, as well as sleep and food deprivation. In extreme cases, physical torture and starvation may be used.
- Confusion and uncertainty. Personal belief systems and entire ideological orientations are challenged. Person's uncertainty about their own fate is linked to uncertainty concerning their beliefs and values.
- Guilt and humiliation. A sense of guilt and personal humiliation (shame) is induced by a variety of techniques. All are directed at making a potential convert feel unworthy if he or she persists in maintaining present commitments.
- Release and resolution. An absolute framework provides only a single 'out'. Suicide is prohibited. Only by compliance or full conversion can individuals gain release from the isolation, pain, guilt, and confusion induced in them by their persuaders.

It is apparent that coercive techniques of persuasion are seldom of an 'all or none' nature. Hood believes that it is best to consider degrees of coercive persuasion, ranging from the extremes of techniques applied to prisoners of war, to the middle range examples of draftees into the military, to the minimal extremes (religious summer-camps for teenagers or sexual reorientation retreats for young adults).

The process outlined above describes the most extreme techniques employed to change or reform firmly held beliefs (such as converting capitalists to communists or agnostics to a Jonestown style cult). The homosexuals who volunteer or are recruited to participate in sexual reorientation interventions bring to the process a long established, culturally reinforced sense of shame and guilt. Without the need to create shame and guilt where none previously existed, the amount of coercion required to 'reform' the thoughts of the already shamed and guilt-ridden homosexual is minimal.

Control and isolation through the prohibition of contact with known gays and lesbians who are 'out' and preferential contact with church members; *social and emotional exhaustion* by means of a heavy schedule of social contact with church members (individual pastoral counseling, small groups, workshops, Bible studies and congregational activities); *confusion and uncertainty* about one's ability to achieve happiness on Earth or Heaven in the after-life versus a life of misery followed by Hell in the absence of exclusive heterosexuality; *guilt and shame* for past and present homoerotic thoughts and behaviors; *release and resolution* promised for heterosexual thoughts and behaviors. All of the above comprise the subtle persuasion of religion based sexual reorientation interventions.

Do such interventions qualify as brainwashing? Probably no more than do similar faith based interventions for disorderly youth or alcohol and drug addicts. Would the above meet the criteria for 'coercive persuasion' when applied to adolescents involuntarily? When escape is impossible and participation mandatory, perhaps it does.

Catholicism, like Judaism is renown for the role of religious and moral guilt and shame. Likewise, Protestant faiths also rely on shame and guilt as tools to shape personal and social behavior. No discussion of sexual reorientation is complete without an in-depth exploration of the role of shame and guilt in the decision to pursue changes in sexual orientation and sexual behavior.

Chapter 18: Bioethics of Sexual Shame

> What a chimera then is man! What a novelty!
> What a monster, what a chaos, what a contradiction,
> What a prodigy! Judge of all things, feeble earthworm,
> Depository of truth, a sink of uncertainty and error,
> the glory and the shame of the universe.
>
> Blaise Pascal, Lettres Provinciales.

Internalized homophobia is all about shame. Gay affirming therapies are all about pride. Shame must be explored as a motivator for sexual reorientation, as a by-product of unsuccessful reorientation interventions, as a phenomenon associated with relapse following quasi-successful interventions and as a clinical indicator for a referral for gay-affirming therapies. The impact of shame on the individual non-heterosexual as well as group shame must be examined as part of this debate. What is the appropriate response of an individual clinician or the heath system to individual or group shame?

Shame: A Literary and Philosophical Background

Despite the debilitating effects of shame, only recently has it been considered a relevant focus of psychotherapy. Generations of therapists viewed shame as a source of resistance against nobler drives and feelings (Morrison, 1998). Helen Block Lewis, one of the first psychoanalysts to write extensively about shame, believed that shame overlooked in treatment ('by-passed shame') was a major cause of failure in psychotherapy (Lewis, 1971).

The Old Testament is full of references to shame, even in circumstances that are more accurately said to represent guilt (Morrison, 1998). For example:

> *From our early days*
> *Baal, god of shame, has devoured*
> *The fruits of our father's labors,*
> *their flocks and herd, their sons and daughters.*
> *Let us lie down in shame, wrapped round by our dishonor,*
> *For we have sinned against the Lord our God,*
> *Both we and our fathers,*
> *From our early days till now,*
> *and we have not obeyed the Lord our God (Jeremiah 3:24-25).*

Unto thee they cried and were delivered:
In thee they trusted and were not put to shame.
But I am a worm, not a man,
abused by all men, scorned by the people.
All who see me, jeer at me,
make mouths at me and wag their heads (Psalms 22:11).

Enlighten our eyes in thy Torah;
attach our hearts to thy commandments;
Unite our heart to love and reverence thy name,
so that we never be put to shame. (Sabbath Service)

The above quotations from the Old Testament and the Torah describe responses that play a central role in the experience of shame; lying down, covering, and blushing. Morrison finds it interesting that, with the advent of Christianity and the New Testament, the emphasis is reversed and much greater attention is paid to guilt – including some occasions when guilt is the ascribed emotion although shame would be more appropriate.

Great novelists have also explored shame as a crucial element of the human condition. Shakespeare's works are replete with shame, as when Lear rails against the injustice of his aging and his waning powers (Morrison, 1998). Dostoyevsky's *Notes from the Underground* is a chilling account of self-abasement and degradation in which the narrator relates his many humiliations, as in the moment when Lia arrives and observes him as he shrieks uncontrollably at his servant (Morrison, 1998). In *Anna Karenina*, Tolstoy describes the shame felt by Anna and Levin as each reflects separately on memories and feelings experienced while they were alone, and the relief resulting from the dissipation of shame when they reenter their familiar environments (Morrison, 1998). In Hawthorne's *The Scarlet Letter*, the emblematic 'A' that signifies Hester Prynne's sexual transgression proclaims her shame outwardly, but Hester also burns from her own internal sense of weakness (Morrison, 1998). In Eliot's *Middlemarch*, Mr. Casabon suffers the shame of realizing that his social expectations are not to be readily satisfied, just as other characters in that monumental novel experience shame with their small, tightly knit community (Morrison, 1998).

Kafka's novels are further studies in shame. In *The Trial*, Joseph K. tries to understand which are the failings that have caused him to be interrogated and in *Metamorphosis,* Gregor Samsa finds himself inexplicably transformed from a man into a despicable beetle (Morrison, 1998). Melville's *Moby Dick*, that gargantuan epic of good and evil, vengeance and

obsession, also reflects Ahab's rage against defeat and humiliation (Morrison, 1998). Faulkner's *Light in August* portrays the shame of perceived inferiority, as Joe Christmas is troubled by his ancestry, which is partly black, and by his social and sexual inexperience (Morrison, 1998).

Philosophers have and do explore shame. George Hegel is concerned with self-consciousness and its significance in master-slave relationships, bondage, mastery, and submission – obvious elements in the configuration of shame – writing: "For the sense of shame bears evidence to the separation of man from this natural and sensuous life. The beasts never get so far as this separation, and they feel no shame" (Hegel as quoted by Schneider, 1977). In *Thus Spoke Zarathustra*, Nietzsche describes how God views humankind: "He saw with eyes that saw everything; he saw man's depths and ultimate grounds, all his concealed disgrace and ugliness. His pity knew no shame: he crawled into my dirtiest nooks" (Nietzsche, 1954). Nietzsche also defines liberation as "no longer being ashamed in front of oneself" and laments "the darkening of the heavens over man has always increased in proportion to the growth of man's shame before man (Nietzsche, 1882, 1887). Sartre (1956) notes the painful entwining of shame and self-identity:

> "Consider for example shame ... it is a shameful apprehension of something and this something is me. I am ashamed of what I am. Shame therefore realized an intimate relation of myself to myself. Through shame I have discovered an aspect of my being ... I recognize that I am as the Other sees me. (p.23)"

In the writings of Hegel, Nietzsche and Sartre, one finds shared motifs and themes of shame: the eyes that perceive shame; disgrace, ugliness, and dirt; feeling shame in front of oneself (internal, private shame); feeling shame 'of what I am'. Thus, we learn that shame is visible, dirty, can be solitary and private, and is about the self (Morrison, 1998). Morrison defines shame as:

> " ... that feeling of self-castigation which arises when we are convinced that there is something about ourselves that is wrong, inferior, flawed, weak or dirty. Shame is fundamentally a feeling of loathing against ourselves, a hateful vision of ourselves through our own eyes – although this vision may be determined by how we expect or believe other people are experiencing us. Generally this vision is accompanied by self-consciousness, and by a conviction of important failure that often generates a wish to hide or conceal. A common reaction to shame may be expressed as "I could have sunk into the ground" or, analogously, "I could have died!" The reference to death brings to mind a common synonym of shame – mortification. This definition of shame focuses on self-experience and thus

> contrasts with guilt, which tends to focus on a harmful action or omission, a deed that causes pain to another. As guilt generates confession and the goal of forgiveness, shame generates concealment and hiding, and the wish for acceptance (by self and others) (p.103)."

As is evidenced by literature and philosophy, shame has evolved through the ages and is dependent on both culture and social status. Twentieth century feminist writers and philosophers have dedicated volumes to exploration of the origins and consequences of gender-based shame both through history and across cultures. Queer philosophers speak to sexual shame as a tool for control and manipulation of the masses, particularly as the power of the Church has begun to wane in modern and postmodern ages. Queer philosophers would argue that sexual shaming can never be tolerated and must be exposed as the tool for manipulation and control that it is.

Psychotherapy can become the setting for the generation as well as the resolution of shame. Although Freud touched upon the topic of shame in his early theories of psychoanalysis, he never made of it a central focus. In fact, he was quite ambiguous in his treatment of shame, sometimes referring to it as a defense against sexuality and the basic drives (Freud, 1905), and at other times as a feeling and an affective experience (Freud, 1900).

Morrison suggests that one possible explanation for why shame is overlooked by psychotherapists is its contagious nature. In contrast to guilt (which has to do with harmful actions or thoughts against others), shame is difficult to encounter in another without recalling and even re-experiencing one's own shame experiences. He posits that, since guilt inducing behavior is specific to a given person, it doesn't usually reverberate with someone else's experience. On the other hand, another person's shame recalls our own feelings of failure, inferiority, and incompetence.

In psychotherapy the emergence of shame tends to generate a collusion of avoidance between the therapist and patient; both 'avert the eyes' in embarrassment as they turn away from shame to deal with more palatable problems such as depression, anger, anxiety, which do not so readily trigger evasion (Boucek, 1991; Morrison, 1989). Morrison emphasizes that:

> " ... shame is difficult to treat because, so often, it is difficult to find. We hide our shame behind guises of anger, contempt, depression, denial or superiority. These guises or masks can be so compelling that therapists tend to treat only them, ignoring the underlying, core feeling of shame. But the

> therapist's task is to remove the mask of deception and expose shame, to speak of it directly and respectfully, and then to try to find ways to lift its burden through genuine self-acceptance (p.34)."

Cultural anthropologist M. B. Singer (1953) states:

> "The prevailing criterion for distinguishing shame and guilt cultures has been the distinction between external and internal sanctions. If a culture depends primarily on external sanctions, it is considered to be a shame culture (p.49)."

Margaret Mead contends that internal sanctions represent internalized sources of conformity and authority that operate automatically, as part of the individual's character, citing guilt as a prime example (Piers & Singer, 1971).

Homosexuality and Shame

Case: Shaming as Abuse

Morrison offers a good clinical example of shame as abuse.

> A patient, Edward, describes memories of his father taunting him for being effeminate. A homosexual artist, Edward recalled constantly being made to feel that there was something wrong with him for being interested in 'the pretty things that only girls are supposed to like' and for not liking 'boy things'. One particularly painful event occurred at a large party given for one of his relatives. As he was greeting some cousins, his father suddenly pulled him into a corner of the room, saying: "Do you have to wave your hands around like that when you are talking? You embarrass the hell out of me when you do that!" His father, himself very shame sensitive, tormented his son for being 'different', for not being 'manly'. Not surprisingly, Edward is very ashamed about 'the way he is' and hides his homosexuality from his work associates for fear of being taunted and humiliated, as he so often was by his father (Morrison, 1998, p.114).

An emotionally or physically brutal environment precipitates chronic feelings of shame; self-blame and shame become ingrained attempts to make sense out of being victimized (Morrison, 1998). Were Edward to request referral for possible sexual reorientation intervention, it would be important to fully explore the impact and origin of Edward's sexual shame prior to making a clinical recommendation. In this instance, sexual reorientation may not address the true issue to be resolved.

This case was selected to highlight the relationship between clinical formulation and choice of intervention. For Edward, the clinical task is to first resolve the shame originating

(1998) notes that as narcissism and an emphasis on 'self' have gained prominence in recent decades, shame inevitably takes its place as the dominant feeling of failure, inferiority, defect, and insignificance in the attainment of personally and culturally valued aspirations and ideals. Requests for referrals to sexual reorientation interventionists require that the clinician and the patient be willing to explore the importance of personal and cultural values and ideals.

Philosophers have considered the development of shame through parental misattunement and preoccupation, the role of ideals and unreachable aspirations and the dominant part played by society in setting the stage for shame through poverty, racism, sexual abuse, harassment, addictions, and the stigmas of illness, homosexuality and aging (Morrison, 1998). Clinicians providing sexual reorientation must be able to explore sexual shame from these philosophical perspectives as well as diverse cultural perspectives as part of the clinical evaluation.

Social theorist Lasch (1992) has written in favor of shame, and against a social emphasis on self-esteem, which he sees as lowering personal standards and values leading to a society of shamelessness. His is clearly a minority view in the twenty-first century (Morrison, 1998), although one shared by many who would recommend sexual reorientation indiscriminately and irresponsibly.

Morrison (1998) describes three means to productive healing and alleviation of shame. These include societal, individual, and psychotherapeutic changes, discussed below:

Societal

It has been often taught that certain repetitive social conditions promote shame. According to Morrison among other, these include:

> ... childhood sexual abuse, harassment, rape, poverty, racism, sexism, addictions, societal responses to homosexuality, and feelings about aging and illness. Some approaches to alleviating shame include attempts at social change, such as affirmative action, economic justice, equality in the work and market place, etc. Other approaches include efforts to change the subjective perception by disenfranchised groups and classes. Examples of these include black power, feminism, Alcoholics Anonymous, the labor movement, Zionism, gay liberation, Gray panthers, etc. The distinction between societal and personal efforts cannot be made too rigidly, since the efforts of the individual – whether through psychotherapy or alone – to become free of stigmas imposed by childhood trauma or cultural happenstance include both elements (Morrison, 1998, p.114).

One important relationship between shame and society is the violence that unremitting shame and oppression engender. While violence can hardly be advocated as a useful way to resolve shame – whether through domestic fights or social upheaval and riots – the direct relationship between feelings of passivity and shame and attempted resolution of these through action, aggression, and retaliation is well documented. Violence may well be the outcome when society fails to address or redress the inequities and humiliations within its purview, as occurred in the case of the Stonewall riots[3] in New York City.

Individual

Morrison postulates that since shame represents feelings of failure, flaws, and inferiority – the gap between who we want to be and who we think (or fear) we are – we become drawn toward individual approaches to easing shame's affliction. The most compelling involve efforts to address the internal voice that 'documents' our shortcomings. We reflect on who it was that ignored, mocked, or abandoned us during childhood, and attempt to remind ourselves that such a self-vision is ancient, inaccurate, and not our own.

In addition to reworking the internal voices that remind us of our failures and inadequacies we also have the potential to reshape the ideals we believe in, which are largely beyond our capacity. It is common to suppose that one would be loved by the internal or fantasized 'other' - if only certain attributes (intelligence, wealth, etc.) were present. When these goals or ideals inevitably prove unreachable, we torment ourselves with the failures and defects that accompany them – the 'malady of the ideal' (often occurs when success with efforts to change one's sexual orientation become elusive). This dynamic mandates efforts at easing or lowering the standards of the 'impossible dream'. On the other hand, in those instances where our shame comes from the impediments that we put in the way of our own potential success, we can work at removing barriers to goals and competencies that seem appropriate (often an essential component of gay affirming therapies). While most instances of shame reflect voices that mock us, or create ideals that are unattainable, some efforts toward reaching specific attainable goals can generate pride and ease shame. Attempts at overcoming roadblocks to success are usually precluded by the very defenses and conflicts (often

[3] Stonewall riots: landmark historic event that marks the beginning of the gay civil rights movement in America.

including guilt) that have generated the problem in the first place. However occasionally, regaining previously developed skills can yield self-affirming results. (p. 201)

Psychotherapy

Morrison offered up the prior examples of individual tasks to ease shame. They are relevant to:

> ...the psychotherapy of shame, with the help of a skilled professional to help direct one's efforts, and the potentially useful presence of transference feelings and insights in shaping them. The psychotherapist can help to alert the patient to the presence of shame underlying feelings of distress, reactions of rage and contempt, etc. (assuming, of course, that the therapist is attuned to the importance and ubiquity of shame, and the various guises it assumes). The therapist can articulate the punitive, harsh, and condemnatory interior voices of figures from the distant past, whose criticism or lack of interest continues to shape negative convictions about the self. Therapy can help to recover memories of less harsh, more accepting and loving persons who may have been pushed to the background of the interior landscape, but whose affirming voices may help to counter self-imposed images of failure and unworthiness. Therapy can be used to alter aspirations and ideals unrelentingly beyond reach, and to overcome resistance against working at tasks that can be achieved to affirm potential competence (Morrison, 1998, p.215).

Such psychotherapies can be undertaken as a prelude to eventual sexual reorientation interventions or gay-affirming psychotherapies. In either case, it is very important to acknowledge sexual shame as an issue distinct from sexual behavior or orientation.

Implications for Sexual Reorientation Interventions

Both sexual reorientation interventions and gay affirming therapies share the goal of relieving shame and guilt. Sexual reorientation interventions work to strengthen internal heterosexuality and overt heterosexual behavior, resulting in improved self-esteem and the beginnings of a sense of pride in one's sexuality. Sexual reorientation providers would describe as a success an intervention that increases the quantity and quality of heterosexual activity while diminishing or eliminating the homosexual behavior that is associated with shame and guilt. Alternatively, the gay affirming therapist works to relieve shame through the development of self-acceptance and, eventually, pride in one's non-heterosexuality.

Religious groups offer 'transformational ministries' as an intervention to relieve the shame and guilt experienced by both religious and non-religious homosexuals. These interventions promise forgiveness, hope, support, and relief from hiding one's struggle with the moral and social shame that is homosexuality. Gay, lesbian, feminist, and queer political groups attempt to relieve the shame experienced by homosexuals through social changes in legislation, media, popular opinion, public and professional policy changes. Examples include the removal of homosexuality from the American Psychiatric Association's *Diagnostic and Statistical Manual*, changes to the professional policies and guidelines of organized medicine to discourage or prohibit discrimination of patient access to care based on patient sexual orientation or sexual behavior, discrimination of provider access to training or professional memberships based on provider sexual orientation or sexual behavior, sexual reorientation interventions, initiatives in support of same-sex domestic partner laws for dependent health care coverage and the legitimization of same-sex unions, etc.

Clinicians involved in the practice of sexual reorientation must acknowledge and be able to tolerate an in depth look at the role of shame and guilt for motivating requests to change one's sexual behaviors or sexual orientations. The clinical literature suggests that both reorientation interventions as well as affirming interventions have both successes and failures. Relief of shame is one way to compare and contrast treatment efficacy between such very disparate interventions as reorientation and affirming interventions. Another is to analyze initial characteristics evident between the successes and failures within a given intervention as well as between interventions. As described above, shame can serve as both an outcome measure (a way to quantify efficacy) as well as an initial clinical descriptor (with predictive powers). Shame and sexual orientation is a field of study that warrants further clinical research.

Chapter 19: Bioethics and Psychiatry

The evolution of professional ethics in psychiatry and psychology has followed the larger trends in Western health care. Among health professionals, the pull towards paternalism is perhaps the strongest for psychiatrists because of the intense dependency and vulnerability of psychiatric patients combined with the omnipresent monitoring for impairments in judgment and competence required by mental health practice. The mental health providers that offer sexual reorientation interventions are major stakeholders in this debate, any discussion must look at their ethical past, present and future.

The Declaration of Madrid

The World Psychiatric Association's (WPA) Declaration of Madrid, adopted in 1996, was endorsed by the American Psychiatric Association five years later, but not, according to Alan Stone (2002), without much-needed qualifications. The Declaration of Madrid was supposed to deal with ethical guidelines for psychiatrists, but in fact its standards have more to do with law and legal reasoning than with medicine and traditional medical ethics (Stone, 2002). The American Psychiatric Association and its Council on Psychiatry and Law successfully pressed for the qualifications. Stone notes that, especially in America, the law has dramatically transformed the domain of psychiatric ethics. The dramatic shifts in psychiatric ethics over the last three decades have left many practitioners anxious about legal consequences and eager for concrete standards of care and professional guidelines to follow.

The Declaration of Madrid is filled with loans from American law and couched in legal terms without any apparent recognition of the legal consequences, worries Stone. The first standard calls on psychiatrists worldwide to provide treatment in 'the least restrictive setting', a phrase taken directly from the American constitutional doctrine which was the rallying cry of the civil libertarian movement that brought down the walls of American state hospitals in the 1970s. Stone believes that it was legal rhetoric that destroyed psychiatric institutions without creating alternative systems of care, a process that highlights the risk of placing professional ethics and bioethics entirely in the realm of public policy and law.

Most of what the WPA now adopts as 'ethical standards for psychiatric practice' were, in fact, forced by lawyers on American psychiatrists and physicians. Stone notes that 'informed consent' was an idea thrust on a reluctant American medical profession by judges dealing

with cases of malpractice and negligence. Any medical historian will confirm that 40 years ago medical students in America and elsewhere were still taught not to tell patients that they had cancer! Stone believes that subsequent generations of doctors have made informed consent and patient autonomy the core of their ethics, without recognizing that these principles were imposed on them by the courts rather than derived from a tradition of medical ethics or practice. Stone's concern is that the language of Madrid's third ethical standard could have been taken from Canterbury v. Spence, 464 F2d 772 (DC Cir 1972), the benchmark decision on informed consent. The Declaration of Madrid makes the patient "a partner by right in the therapeutic process" and imposes on the doctor the "duty ... to provide the patient with relevant information so as to empower the patient to come to a rational decision according to his or her personal values and preferences." This is certainly an important ideal for all physicians, but it is also one that poses practical problems for psychiatry.

There are some who insist that every patient entering psychotherapy must be told as a matter of informed consent what the scientific evidence of the proposed psychotherapy is, in comparison to that of medication for the same condition, as well as the likely outcome if no intervention is made. Stone is concerned as to the implementation of the ethical ideal of informed consent when the patient is floridly psychotic and in urgent need of care.

Stone asserts that the Declaration of Madrid has no foundation in traditional medical ethics, as evidenced by the failure to mention the ancient injunction *primum non nocere* (first, do no harm). Which is actually understood to mean "above all, don't do more harm than good." He worries about how the modern psychiatrist can proceed when the least restrictive environment available carries a substantial risk of harm.

This shift away from medical ethics towards legal precedent in psychiatric bioethics may reveal a weakness in organized psychiatry's ability to evolve ethics that are applicable to twenty-first century mental health care. If the events resulting from the WPA's Declaration of Madrid are symptomatic of an inherent instability or insufficiency of ethical philosophy in psychiatry, it seems incumbent upon all psychiatric professionals to critically evaluate the ethical guidelines propagated by organized psychiatry and organized mental health.

Postmodern Psychiatry

In the March 2001 issue of the *British Medical Journal*, psychiatrists Patrick Bracken and Philip Thomas outlined a "new positive direction for the theory and practice in mental health." This movement has been dubbed postpsychiatry (also known as postmodern psychiatry) and it is notable that many of its aims are broadly shared with Queer Theory. It is responsible for a number of recommendations relevant to the debate on sexual reorientation interventions:

- A rejection of "faith in the ability of science and technology to resolve human and social problems."
- A rejection of "the medical control of coercive interventions."
- A rejection of "the emphasis on the individual's circumstances and traits in understanding psychiatric disorders."

Braken and Thomas emphasize that psychiatry must move beyond its modernist framework to engage with government proposals and the growing power of service users. These tasks are problematic for American psychiatry given the excursions of the legal and political system into the professional arena over the last four decades. Braken and Thomas view postmodernity as providing an opportunity for doctors to redefine their roles and responsibilities, particularly appropriate for a field that has most recently been subject to redefinition by consumer groups, political groups and courts.

Bracken and Thomas provide a unifying framework for these particular proposals by referring to the roots of modern psychiatry in the European Enlightenment and its resulting characteristics (Radden, 2001). Each tenet, according to Radden, derives from an aspect of the 'postmodernist' rejection of Enlightenment concepts, categories, and methodology. According to contemporary historians influenced by Foucault, the Enlightenment, with its emphasis on reason and rationality, led not only to the social exclusion of the mad as unreasonable, but also to their role as objects of study and treatment using rational scientific methods (Radden, 2001). The Enlightenment, with its emphasis on the individual subject, invited a 'de-contextualizing' of mental disorder, emphasizing disorders of individuals, not products of social, cultural or economic forces. Radden (2001) notes that with this theoretical background, the thematic unity of postpsychiatry becomes clear.

> If we reject the Enlightenment focus on the isolated individual with its adherence to methodological individualism, then we lose confidence in any appeal to individual circumstances and traits to explain and understand psychiatric disorder. If we reject the normative dualism which contrasts rationality with irrationality or unreason, we lose faith not only in rational scientific method with its (technologic) tools, but also in a perceived underpinning of coercive psychiatry, the scientific authority and moral warrant for imposing treatment against the patient's wishes (Bracken & Thomas, 2001, p.2).

According to Radden, the new agenda for mental health care dictated by postpsychiatry places emphasis on context ("social, political and cultural realities should be central to our understanding of madness"); on group, rather than individual, responses to disorder (this includes acknowledgement of the social and economic causes of mental disorder as well as networking and self-help, client group approaches to treatment); and an ethical orientation (rather than "the idea that science should guide clinical practice"). Recommendations are not detailed fully, but they include an approach with more sensitivity to cultural variation and values in treatment (Radden, 2001).

Radden worries that this new agenda, however appealing and desirable, is derived from overstated postmodernist theorizing and dangerously open to misinterpretation. Braken and Thomas appeal to Muir Gray's characterization of the priorities of today's society to which all in health care must be responsive - concern about values as well as evidence; preoccupation with risks as well as benefits; and the rise in prevalence of the informed patient. Radden notes that the informed risk evaluations made by the patient in contemporary health care settings are possible on the one hand thanks to information about risks and benefits provided, in part, through science and technology and on the other because of an acknowledgement of the patient's (rational) autonomy as a value to be honored.

It is worth bearing in mind that postmodern psychiatry may carry the same threat as Queer Theory in terms of risk for destabilization of group and individual identities. Braken and Thomas ask how appropriate Western psychiatry is for cultural groups who value a spiritual ordering of the world and an ethical emphasis on the importance of family and community. Queer and essentialist theory, with their Foucaultian heritage, inevitably force psychiatric and mental health policy makers to re-examine policy making practices which address the social goals of specific bourgeois sub-cultures in twenty-first century Western society at the expense of sub-cultures marginalized by virtue of size, value-system, religious beliefs or non-Western

origins. It is exceedingly difficult to provide policy guidelines that address and respect both the bourgeoisie and the marginalized in the diversified societies of North America and Western Europe. This argues for a locus of ethical control between the patient and clinician instead of within professional organizations.

Value-Sensitive Therapy

Value sensitive therapy highlights the importance of the individual practitioner and patient in the evolution of ethical decisions. Essential to the process of psychotherapy is the assumption that, at some point, both patient and therapist will share a perception of what is wrong, what needs to be corrected, and how the therapist can assist in effecting the repair. Heilman and Witztum (1997) note that behind this fundamental cognitive assumption is another supposition: that both the patient and the therapist hold a common value orientation with respect to what would be a satisfactory resolution of the distress that has brought the patient to the therapist. When patient and therapist do not share common values, the therapist must create a strategy for the two to find some common cultural ground on which to meet in order to enable them to 'speak some common language'.

Heilman and Witztum note that in most cases, the patient must learn to accept the standard metaphors of illness and therapy. Moreover, he or she is also often required to accept the therapist's "judgements concerning the desirability and advisability of various courses of action (p.4)." Sometimes, as has been argued in the literature on the development of 'culturally sensitive' mental health training (particularly in the context of therapists from the dominant culture treating those of a minority culture), it calls for the mental health professional to reframe their diagnosis and try to perceive the reality of the situation not just through the therapist's explanatory framework but also through the prism of the patient's complex of cultural metaphors (Bilu et al, 1994; Crapanzano, 1973; Kleinman, 1980). The decision to provide or withhold a referral to a sexual reorientation interventionist requested by a patient requires the clinician to look at and assess the similarities and differences in the value systems held by the patient and the clinician:

> When the divide across which the therapy occurs defines different cultural realities but also contradictory and mutually exclusive values, a cognitive understanding of difference may be insufficient. The therapist must also pursue a therapeutic strategy that is sensitive to the patient's values, even when this seems

> to oppose commonly accepted therapeutic approaches, so that the patients do not emerge from the encounter having been healed and also 'converted' to a new set of values that undermine a sacred or social order that matters deeply to them. Perhaps nowhere do these issues become clearer than in the case of an encounter between a secular therapist, trained in modern therapeutic methods, and a religious patient, bonded to a traditional community of believers whose heritage and folkways are incongruent with the values and cultural assumptions shared by most psychotherapists (Heilman & Witztum, 1997, p.12).

To be value-sensitive, of course, is not to be value-free. As Bergin, and before him Max Weber assert, a totally "value-free approach is impossible" (Heilman & Witztum, 1997, p.12). Value sensitivity requires clinical sophistication and expertise that cannot easily be translated into public policy or professional standards. The following case is quoted in full from Heilman and Wiztum because it illuminates well the complexity and importance of value sensitivity in clinical practice.

Case Study: The Homosexual Rabbi

> Rabbi Eliezer was a 52-year-old, Haredi[4] man from Jerusalem with a severe appearance. A product of the yeshiva world, he excelled in Torah scholarship and became a Rosh Yeshiva. He was married and father to five children, ranging in age from an 18-year-old daughter to a 25-year-old son. Suffering from impotence, Rabbi Eliezer first visited an urologist. Finding no organic reason for the problem, the urologist referred him for a psychiatric consultation.
>
> During the intake interview, Rabbi Eliezer kept his features tightly controlled most of the time. In response to probing questions, he revealed that his impotence emerged about four months after his youngest daughter's wedding. Describing the wedding, he spoke glowingly of his new son-in-law. He became animated and his severe features visibly softened as he characterized the young man as an outstanding rabbinical student (standard praise used to describe young males (so-called b'nai torah) – especially by someone who is Rosh Yeshiva.) But then, he went beyond this characterization and declared that his new son-in-law was a handsome lad, making use of a Biblical phrase (Sam. I 16:12), '*adonee v'yefay einaim v'tov roeey*' (ruddy with beautiful eyes and good-looking), an expression used to describe the legendary King David. Although couched in Scriptural language, the use of this sort of description in reference to a young man's physical appearance is unusual in the world of Haredi rabbis. These are simply not qualities that are expected to feature prominently in a rabbi's assessment, even of his son-in-law. This is because the rabbi is supposed to be concerned with the young man's interior, his mind, his learning – but definitely not his body. If he

[4] Haredi: a strict, conservative Jewish sect prominent in New York City and Jerusalem.

shows any concern for his appearance, it would normally be something that referred to his modesty or humble dress. But Rabbi Eliezer focused on the young man's physical beauty.

After additional probing, he further revealed that he was extremely fond of the young man. In the world of the Haredim, where all marriages are arranged, this young man had been put forward by a matchmaker. However, when Rabbi Eliezer met him, he was very much taken with the boy and strongly encouraged his daughter to accept the match and embrace the marriage. And, indeed, the daughter acceded to her father's wishes, which were not at odds with her own.

After the wedding, the young couple lived for three months near the bride's parents. During this time, Rabbi Eliezer often found himself daydreaming about his new son-in-law. As he described these visions, he said he dreamt that he was sitting studying Torah with the young man, an activity in which he often engaged in actuality. He also dreamt about the young man at night. He denied that these dreams were erotic in any way, but admitted that they were quite clear and focused on the young man.

When asked, he claimed he had never had such dreams before in his life. As for his own sons, he would only say that he was an extremely strict father to them, perhaps – he admitted – too strict. Conversely, he claimed he was too lenient and forgiving towards his daughters.

A computation of the age of his children and his own age reveals that Rabbi Eliezer did not marry until the age of 27, which is most unusual in the Haredi world in which males usually marry between the ages of 18 and 22. To have wed at 27 suggests that Rabbi Eliezer had such difficulties in finding a mate that the matchmakers could not 'sell' him in the marriage market. When asked to account for his late marriage, he explained that 'no girl was good enough for him', and therefore he had rejected many of the potential brides. Finally, his father grew ill and revealed that his continuing status as a single man was deeply disturbing. Just at that point, he received an offer from America for a wife, which he accepted.

For many years his sex life was, according to him, quite satisfactory, and in fact he fathered five children. His wife later confirmed that she had no complaints about his sexual behavior until the onset of his impotence which came when, four months after their wedding, the daughter and son-in-law followed a common Haredi practice and moved to another city where they had found an apartment they could afford and where the young man found habilitation as a student in a kollel. During the month following their departure, Rabbi Eliezer said that he longed powerfully for the young man. He also became sexually impotent at this time.

It is important to note that the rabbi did not himself make an explicit connection between the two events. Indeed, he ignored any possible linkage between them. Instead, he worried that he had somehow sinned – though precisely how he could not say – and that this was the reason this grievous illness had come upon him. Although he suspected a religious root to his problem, he had not discussed the possible nature of his sins with any other rabbis because he considered his affliction to be intimate and embarrassing.

> Later, when Rabbi Eliezer's wife came for her interview with the therapist, she inquired as to whether there could be an association between her husband's condition and the departure of the young man, who, as everyone knew, the rabbi adored. Tentatively broaching the subject in a subsequent interview, the therapist asked Rabbi Eliezer if he had encouraged his daughter to marry the young man in order to 'acquire' him for himself though the medium of his daughter. Rabbi Eliezer nodded in affirmation, believing himself to be admitting his wish to acquire the son-in-law as a student and disciple rather than the presence of any illicit desires.

The Therapist's Dilemma

> According to the therapist's evaluation, this was a case of latent, repressed homosexuality, something that probably contributed to the patient's earlier inability to find any woman good enough for him to marry. Sensing his erotic feelings for his son-in-law, Rabbi Eliezer had perhaps become overwhelmed and frightened by his own homosexual desires and, having lost the young man, found that his libido had become totally inhibited. Alternatively, the impotence could be explained as an effort on the rabbi's part to 'punish' himself for his forbidden desires and appetites, thus eliminating the possibility of all potential sexual satisfaction. Finally, his impotence might be explained as a self-inflicted 'brake' or inhibitor preventing his desires from driving him toward an act of sexual satisfaction (either homosexual or masturbatory, both of which were strictly prohibited) that he would always regret. Whatever explanation one accepts, each one has, as its precipitating factor, the latent homosexual desire for the young man - a desire that is totally incompatible with Rabbi Eliezer's Haredi religious and cultural values, which view homosexuality as an abomination.
>
> In fact, the problems from which Rabbi Eliezer suffers might be alleviated by a therapy leading to his recognition and ultimate acceptance of his homosexual or bisexual character. However, while this might solve the problem of his impotence, it would also ban him forever from the only world and set of values he has ever known and leave him completely isolated. Ironically, he would be even further from his love object by virtue of this disclosure and life change than he already was. Even if he were not to express his homosexuality but simply admit it, the revelation would have the same culturally disruptive and emotionally burdensome effects (Heilman & Witztum, 1997, p.9).

The therapist in this situation is confronted by a dilemma. Should he reveal to the rabbi his apparent homosexual or bisexual nature, or should he help the rabbi to suppress or sublimate it so that he can continue to live in the sexually regulated and highly structured Haredi world where no variations on the basic monogamous heterosexual union are tolerated or even legitimately contemplated? In value terms, what is good and what is bad? The answer is far from clear.

> Clearly, therapists are, in some ways, agents of social and cultural order, and their decision regarding what strategy to take is affected not only by the desire to make the patient well, but by a judgment as to which world and value system the patient should participate in in order to be well. What constitutes wellness in San Francisco is very different from the form it takes in the Haredi neighborhoods of Jerusalem where Rabbi Eliezer had made his life. Hence therapy requires a clear sense of where in the world the patient is being sent when he gets well. The therapist must therefore not only cure the patient but also relocate him into one world or another. That decision must be made in cooperation with the patient and in such a way that will not cure the illness only to leave the patient a socially crippled individual and cultural loner (Heilman & Witztum, 1997, p.10).

In this case, the psychiatrist dealt with the symptoms focally by the use of medication and relaxation techniques and intentionally avoided giving a psychodynamic interpretation of the symptoms that would allow the rabbi to face the underlying issues of his sexuality. In brief, he decided not to share his own knowledge and insights with Rabbi Eliezer, telling his wife that it was not a good idea to explore the reasons for his impotence too deeply – a restriction which she was able to accept (the notion that there are some matters which should not be explored too deeply is well rooted in Haredi life which emphasizes the restriction of free inquiry) (p.10).

> Ironically, the rabbi himself began to reach some insights into the sources of his problem and himself raised the possibility of his homosexuality, which he immediately denied, adding that if it were true, he would kill himself in such a way that no one would know he had committed suicide. The therapist concluded that this was a thinly disguised way in which to ratify his value-sensitive approach. The rabbi was confirming that he did not want to know or have confirmed suspicions of his homosexuality. He would, he indicated, rather deal with the symptoms than the root cause. With a value-sensitive response, the therapist tried to provide the treatment the culture and the patient wanted. This turned out to be a successful approach (Heilman & Witztum, 1997, p.13).

Heilman and Witztum presented this case as one of three to illustrate that it is not always possible for the 'value-neutral' therapist to seek a 'pure' cure. They emphasize that the responsibilities of the mental health professional include not only helping patients to resolve their particular psychological distress, but also to consider their wider values and cultural interests. This remains especially important when these values or cultural interests are incongruent with the therapist's values or cultural interests or with the classic professional stance of value-neutrality or even when, because of immediate distress, the patient is temporarily oblivious of the threat that their therapy poses to their own deeply held values.

The most recent trend in American mental policy development around sexual orientation both overtly and covertly articulates the value system of the gay, lesbian, and queer communities, often to the exclusion of other perspectives. It is often viewed as politically incorrect to in any way acknowledge the legitimacy of any system (cultural or religious) with heterosexist values. The case of Rabbi Eliezer explicitly demonstrates the clinical risks associated with a broad all inclusive public health policy that would mandate gay affirming therapy as the only appropriate intervention. Any efforts to directly acknowledge or to develop a 'gay identity' for Rabbi Eliezer would have been a clinical misadventure with negligent and inexcusable risks. Value sensitivity rejects clinical decision-making based solely on political correctness or the provider's individual value system and highlights the importance of clinical decisions being tied to the individual clinical situation of the patient, his culture, and his environment.

SECTION VI: BIOETHICAL ANALYSIS

This thesis has attempted, so far, to describe and present clearly the ethical questions raised by the public and professional debate surrounding sexual reorientation interventions, the stakeholders in the ethical debate and their issues. The ethical issues have been explored from biomedical, psychiatric, religious, philosophical, lesbigay, and queer perspectives. Two primary issues lie at the core of this debate, the first is the location where ethical decisions are resolved and the second is how the ethical decisions are resolved. The options for the location include: 1) resolution between the individual clinician and patient, 2) formulation of a unified professional standard of practice across all the disciplines that are involved in the provision of sexual reorientation interventions, 3) a legislated public policy derived from input from the various stakeholder groups in society that supercedes any ethical attempts to resolve the matter otherwise. How the ethical debate is resolved largely depends on where the resolution attempt occurs, and who is involved, but any resolution must be able to reconcile conflicts between fundamental ethical principles such as autonomy, beneficence, non-maleficence and justice; as well as clarifying the intentional and unintentional misconceptions and distortions inherently associated with any public debate.

Chapter 20: Postmodern Bioethics as a Comprehensive Final Analysis

A comprehensive final analysis for this research thesis that looks into the bioethical questions surrounding the provision of sexual reorientation interventions is complete upon resolution of the following questions:

1. What are the reoccurring bioethical principles raised in response to sexual reorientation interventions?
2. Can sexual reorientation interventions be bioethically provided?
3. When should professional organizations for health providers generate policy statements related to the provision of sexual reorientation interventions?
4. Can professional organizations for health providers construct a bioethically sound policy on the provision of sexual reorientation interventions that applies to all professions and all patients, all the time?
5. Who is best prepared to resolve bioethical issues surrounding sexual reorientation interventions?
6. Is there one right answer, if not, why not?

Towards this end, the theories surrounding the potential origins of homosexuality are explored at length; especially those rooted in the psychoanalytic and psychodynamic tradition (Freudian), as these continue to inform sexual reorientation interventions currently available. Less time has been spent in the exploration of Skinnerian behavioral modification programs and learning theory as these treatment modalities for sexual reorientation have largely been abandoned in the America and Western Europe and now are primarily of historic interest. It however remains notable that a number of prominent clinical behavioralists who wrote prolifically in support of behavioral modification interventions for sexual reorientation early in their careers have towards the end of their careers formally reversed their position in the clinical literature and argued against the use of behavioral modification. Their reason for abandoning behavioral modification intervention for sexual reorientation is due to inadequate long-term efficacy. The philosophical work on identity and identity acquisition by Cass is explored in detail and is part of the landscape upon which Queer theorists re-engage the endless debate, of free will versus determinism and nature versus nurture as applied to the socially and politically marginalized sexualities. What becomes clear is that homosexuality is

different between the sexes, across cultures, and across historical time frames. What also becomes clear is that many non-mental health professionals tend to have trouble acting in accordance with the express tenet that homosexuality and other non-heterosexual sexualities have both multiple origins and multiple presentations. This essential tenet is decidedly postmodern.

Postmodern Bioethics

At the heart of postmodern bioethics lies the denial that there are objective bioethical rules available for philosophers or health-care practitioners to uncover. It argues against any hope for an ethical resolution of the public debate surrounding sexual reorientation interventions. This view is explored in depth by postmodern bioethicists such as Englehardt (1996), who has suggested that rational communication about moral issues is no longer possible in a world full of diverging views, and that neither is there any widely accepted moral authority. On the surface, the public and professional debate surrounding sexual reorientation has been so fraught with irrational communication that one might endorse Engelhardt's bleak view and state that professional policy makers will never be able to construct a bioethically sound policy on the provision of sexual reorientation interventions. The data from the model of Campbell and Higgs (1982) identifies a number of problems with the way in which policy statements on sexual reorientation have been constructed by professional organizations, most problematic of which is that bioethics has taken a back seat to the active promotion of social and political agendas.

Engelhardt observed that standards in ethics and bioethics have been sought "in the content of moral thought (e.g. in intuitions), in the form of moral reasoning (e.g. in the idea of impartiality or rationality), or in some external objective reality (e.g. in the consequences of actions or the structure of reality)." Tong (1997) offered the following:

> For example, I 'know' that my intuitions are right because my community thinks they are. I 'know' that I am rational because my community thinks I am. I 'know' which consequences are good because my community identifies them as such. And I 'know' what is natural because my community labels it so. The problem, then, is that my community is not also that of someone else and vice versa. Therefore, when we disagree with each other about the rightness or wrongness of an action, we will not be able to appeal to everyone's intuition, conception of rationality, notion of good consequences, or conception of natural

> acts. Instead, we will be forced to rely on our own moral perceptions as filtered through the conventional principles of our own community (p.79).

Englehardt maintains that in a postmodern society there are only two conventional principles that everyone can invoke irrespective of their 'home base', the principle of permission (respect for autonomy) and the principle of beneficence. Both of which are ammenable to rational discussion.

> The first of these is totally formal and without specific moral content. All the principle of permission tells us is that in a secular pluralistic society, authority for resolving moral disputes "can be derived only from the agreement of the participants, since it cannot derive from rational argument or common belief. Therefore, permission or consent is the origin of authority, and respect of the right of the participants to consent is the necessary condition for the possibility of moral community." Morality cannot be morality unless it concerns itself with "the achievement of good and the avoidance of harm." Granted, one person's good may be another's harm. Nevertheless, even in a secular, pluralistic society, we all have to be committed to pursuing good and avoiding harm in one way or another (Engelhardt, 1996, p.19).

It is not entirely clear that the professional organizations at hand have requested and secured consent from either patients or professionals to assume the authority for resolving the moral disputes that arise around the subject of sexual reorientation. It is clear that none of these organizations can claim anywhere near to 100% membership from the profession they report to represent. It is unclear if any of these organizations presented ever requested or received formal endorsement of their policy statements from their membership. And in terms of a public endorsement (permission) to resolve this moral conflict, it is a far stretch of the imagination to believe the social contract between the public and the health professions gives professional organizations the power to preempt a bioethical discussion of sexual reorientation between a given patient and his clinician.

According to Engelhardt, postmodern medicine is the only type currently possible. Christian Science 'medicine', Jehovah's Witness 'medicine' and Roman Catholic 'medicine' all carry moral weight because a community of believers endorses them as a bioethical system and is prepared to live by their values. However, the medical profession cannot survive as a 'balkanized set of incompatible fiefdoms.' Despite his initial hopelessness, Engelhardt asserts

that for modern medicine, permission (autonomy) and beneficence are ethical tenets well understood and readily accessible to both patients and clinicians.

The broader model of Campbell and Higgs is described in this thesis because it opens the discussion up to a wide range of bioethical and ethical principles with an emphasis on the rational organizing and structuring of discussion with an exploration of what has been said as well as what has gone unsaid. The model of Campbell and Higgs is a powerful tool in that it can accommodate the exploration of specific issues of an individual patient or the global agendas of social groups.

Principlists

Western health professionals are most familiar with a bioethic popularized in medicine by the principlists. Much of the debate on sexual reorientation interventions within the medical profession has been in the language of the principlists such that no bioethical exploration of sexual reorientation is complete without an exploration of such. Tong summarizes the principlists as follows:

> Aware of the strengths as well as the weaknesses of both inductivism and deductivism, the so-called principlists urge a move between particular judgments on the one hand and general norms on the other. They see their primary task as the continual calibration of the balance between these two poles of moral decision-making so that they fit together and reinforce each other. Revealing what has been interpreted as a greater affinity to deductivism than to inductivism, principlists usually undertake this complex process of moral calibration by attending first to the general-norm pole of moral reasoning and then to the particular judgment pole of moral reasoning (hence the name 'principlists').
>
> From the viewpoint of the principlists, the principles of autonomy, beneficence, non-maleficence and justice are in continuous competition for our moral attention. We respond to these principles because each represents a cluster of crucial values embedded in our 'common morality' – that is, the morality that pervades our culture. When we make a moral decision about a particular situation, we are asked to determine rationally which of these values we are bound to follow. To the extent that our decision meshes with the content of our common morality, as developed over decades or even centuries, we can be confident that it is right. However, since our common morality is not an *a priori* set of rigidly ranked absolute principles, true for all times and in all places, but an evolving social institution, our decision may be right even if it departs somewhat from our common morality. After all, morality does not evolve by itself; rather, its progress depends on the wisdom and courage of moral agents to challenge it occasionally (p.21).

The principles of autonomy and justice resonate with fundamental Western morals, whereas the principles of beneficence and non-maleficence hark back to the ancient Hippocratic injunction to act always in the best interests of the patient and, at the very least, to do no harm (Tong, 1997). The language of the principlists is found throughout modern medicine, modern bioethics and sexual reorientation discussions. It is the language that clinicians will use to explore, understand, interpret and discuss bioethical issues with their patients and their professional peers.

Those groups in support of sexual reorientation interventions such as NARTH argue the principles of autonomy and beneficence, while those opposed most often argue the principles of justice[5] and non-maleficence[6]. Beauchamp and Childress (1996) maintain that it is precisely because these principles are so familiar to medicine that professionals rely on them automatically to make judgments about what should or should not be done in particular situations.

Despite the enormous appeal of principled approaches to bioethics, they have been challenged by a variety of critics. Strict deductionists like Clouser and Gert (1990) fault Beauchamp and Childress for offering individuals what they regard as a 'potpourri' of principles. They claim that Beauchamp and Childress simply borrow the principle of beneficence from Mill, the principle of autonomy from Kant, the principle of justice from Rawls, and the principle of non-maleficence from Gert, and present the resultant blend as if it were an integrated and unified theory, when nothing could be further from the truth. They also claim that Beauchamp and Childress encourage moral agents to 'mix and match' the principles of bioethics as they please, "as if one could sometimes be a Kantian and sometimes be a Utilitarian and sometimes something else, without worrying whether the theory one is using is adequate or not (p.28)." According to Clouser and Gert (1990), whenever two or more principles conflict in these situations, decision-makers are left to their own intuition. This state of affairs pushes the principlists into the waiting arms of relativists, who are only too eager to exclaim that there is no 'right' way to resolve a conflict between principles.

From the perspective of inductivists, principlists such as Pellegrino, Thomasma, Beauchamp, and Childress, are to be commended for the extent to which they leave

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[5] Justice: the bioethical principle to do what is right and/or moral.
[6] Non-maleficence: the bioethical principle to minimize harm to the patient.

professionals a measure of moral space within which to exercise their individual powers of judgment. Nonetheless, principlists can be considered lacking, either for awarding the role of principles in biomedical decision-making a privileged position or for underestimating just how susceptible principles are to 'interpretation' – that is, to distortion, manipulation, and the general vagaries of human communication.

Holmes (1990) suggests that the choice of principles is simply the result of our personal predilections. Thus, Holmes charges that whatever a bioethicist claims about the universality or rationality of his principles, "what happens in practice is that he simply chooses a favorite theory and, with the unwitting help of fudge factors, arrives at a 'solution' that he knew to be intuitively acceptable in the first place (p.123)." A dispassionate assessment of the public debate on sexual reorientation tends to support Holmes' view.

Bioethical Analysis of Sexual Reorientation Interventions

Following the framework for ethical analysis advocated by Campbell and Higgs, thus far have been identified the issues at stake, and whom they impact as well as the variety of ways, both direct and indirect, in which the stakeholders are affected. Morally relevant facts, fictions, beliefs, and hypotheses have been explored with an eye towards elucidating the perspectives and purposes of the relevant players in this debate. Campbell and Higgs provide for an exploration of the motivations that drive the bioethical discussion. The principlists (Beauchamp, Childers, Thomasma, and Pellegrino) worry less about what motivates the stakeholders than which principles are used to pursue their ends.

Who has gone unheard?

There is no voice from the unborn offspring aborted during pregnancy, those discarded prior to implantation or experimented on between fertilization and prior to implantation. This is a bioethical dilemma of twenty-first century genetics and fertility technology. Given the powerful shame in many parts of Western society, which is associated with non-heterosexuality as compared to other aspects of individuality potentially under the control of biogenetic technology, the potential for misuse and/or abuse of technology is real. It is foolish to under estimate the power of shame.

Children who have undergone interventions for gender identity disorder have very little voice. Their parents hold the power to consent or refuse medical, psychiatric, and psychological interventions. The literature does not report any feedback from adults or adolescents who underwent interventions for *childhood gender identity disorder* in the past. If we are to hear directly from these children, this is likely to occur as they enter adolescence or adulthood. Their voice remains unheard, either because of a *paucity of numbers* (volume too low) or because *they have no comment* (silent) or perhaps because *no one is listening* (no audience). Those that do speak out approach the subject from either a clinical perspective (outcome studies and technical applications) or from a philosophical perspective (gender dichotomy vs. gender fluidity). In either case they do not speak on behalf of the patients themselves.

Non-heterosexual adolescents as a group are particularly difficult to *listen to* or collect data on given the kaleidoscope of pressures they experience from family, church, school, peers, and self. Adolescence is a period of transition for all aspects of sexuality including sexual orientation and is often marked by being 'in the closet' with some in their environment and 'out of the closet' with others. Both a private and public sexual identity and orientation are being developed.

Closeted homosexuals, non-lesbigay identified homosexuals, and the successfully converted or reoriented group can be equally difficult to fully assess. The shame associated with non-heterosexuality tends to dampen the collective and individual voices of these people. Long-term outcome studies with these groups have been often exceedingly difficult because of their intention to be reassimilated into a heterosexual majority as inconspicuously as possible. Those who participate in such studies find that their sexuality and motivation for participation come under harsh, often unwelcome scrutiny.

Medical and mental health professionals who do not practice sexual reorientation or gay-affirming psychotherapy but who take notice of the trend towards professional policy making driven by political agendas, also seem to have very little voice in the debate. Explanation for this muted voice include perhaps the professional risks associated with being politically incorrect or perhaps professional isolationism[7] or perhaps professional apathy.

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[7] Isolationism: refers to the American political climate 1931-1939 associated with the delay in entry into World War II. "Not my business" thinking.

Misinformation, Language and Conceptual Distortions

It is clear that a number of controversial or unfounded declarations have been made by gay and lesbian groups to discredit sexual reorientation efforts. These mantras include:

- Sexual orientation is *genetically determined* and fixed prior to birth.
- No sexual reorientation intervention has *ever been* successful.
- Research *proves* that sexual reorientation therapies never work.
- Homosexuality is not an accepted diagnosis, therefore it is unethical to treat it.
- Sexual reorientation interventions are *unethical* because they never work and they cause a risk of depression and suicide in the participants.
- The availability of sexual reorientation interventions promotes *homophobia* and *hate crimes.*
- Research on sexual orientation is *unethical.*
- People who request or participate in sexual reorientation are *homophobic.*

The NARTH (representing sexual reorientation therapists), religious groups, and transformational ministries have made a variety of equally inflammatory and unsupported declarations, including:

- Homosexuality *causes* depression, addiction, suicide and AIDS.
- Sexual orientation can be *readily* changed.
- Homosexuality is an *addiction.*
- Sexual reorientation interventions have been successful for *tens of thousands.*
- Conversion to *heterosexuality brings happiness.*
- There exists a gay and lesbian political *conspiracy.*
- American psychiatry and psychology are *controlled* by gay and lesbian politics.
- Sexual reorientation *prevents* AIDS, suicides, addictions, and depression.
- Homosexuality is a *psychological* disorder.
- Homosexuality as a diagnosis for a psychopathological state (disease) was removed because of *political pressure*, not clinical rationale.

All of the above statements contain both a grain of truth with distortion evident of political agenda. Talk of political conspiracies and unethical professionalism fuels the flames of a social and political debate required to reconcile civil rights, civil equality and the social safety of a marginalized group with particular religious and cultural values.

When health providers are exposed to the above rhetoric, it is incumbent upon the individual professional to have enough presence of mind to be able to separate the political agendas from the clinical issues. Arguments like, 'it's not a disease, therefore it's unethical to try to treat it' become diluted when one examines the list of non-diseases and non-disorders that medicine and mental health offer interventions such as: cosmetic surgeries, treatments for mild acne, birth-control, marriage counseling. It is naïve to become dogmatic on this point and believe the issue can be resolved with this line of thinking.

Statements about the success or futility of sexual reorientation interventions all depend on how one defines clinical success or failure. Many proponents of sexual reorientation interventions would view the shift of a bisexual to solely heterosexual intimate contacts or the successful shift to elective celibacy by a homosexual as acceptable outcomes, while opponents would not. Opponents would only view a case as a success when a person transitions from a sustained history of homosexual behavior and internal erotic life (fantasy, arousal) to a sustained history of heterosexual behavior and erotic interest with the elimination of all traces of homosexual behavior or internal same-sex erotic life.

Opponents criticize the current state of research into sexual reorientation interventions as having study design flaws that render the results useless. However, studies on the outcomes of clinical psychotherapy have sustained similar criticism. Other than some reasonably well designed studies in cognitive-behavioral therapy, bereavement counseling and time-limited psychotherapies, most of the evidence for supportive, psychodynamic, and psychoanalytic therapies for various diagnostic pictures are anecdotal case studies or small series. Psychotherapy is exceedingly difficult to study formally, using strict research criteria. The vast bulk of subject matter and the focus of clinical psychotherapy do not have any rigorous clinical outcome research to support the use of psychotherapy. However, therapists abound and are willing to explore virtually any issue within the setting of a fifty-minute psychotherapy hour.

Opponents speak of the risk of depression and suicide associated with failed attempts at sexual reorientation, citing this as a clear contraindication. However, there is no clinical data that correlates failed reorientation with subsequent depression and/or suicide; there is no clear evidence that such a risk is any higher than with other form of elective psychotherapy. Psychoanalysis and psychodynamic psychotherapies often anticipate worsening anxiety and depression during the course of treatment and view this as an essential part of the treatment and as integral to the risks and benefits of the process that must be weighed by the clinician on an individual patient-by-patient basis. If the risk of suicide or depression were found to be predictably increased following sexual reorientation interventions, that might argue against the provision of these services by religious and allied health professionals and in support of restricting them to those with formal mental health training. Of course, prohibiting the provision of sexual reorientation interventions by any professionals could result in a scenario reminiscent of the back-alley abortions in America prior to the U.S. Supreme Court case Roe v. Wade[8].

The American Psychiatric Association has the largest gay, lesbian, and bisexual caucus of any of the member specialties of the American Medical Association, largely composed of psychiatrists. The American Psychological Association and the National Association of Social Workers both have large, vocal gay and lesbian caucuses. Even the most conservative group in American mental health, the American Psychoanalytic Association, has acquired a very prominent and vocal gay and lesbian task force in the course of the last two decades. American mental health has been very attentive to its gay, lesbian, and bisexual members since the 1973 picketing of the American Psychiatric Association's national meeting by gay and lesbian political groups and the HIV/AIDS health crisis of the 1980s.

The removal of homosexuality from the APA's *Diagnostic and Statistical Manual* received national coverage at the time and it continues to be a source of discussion and interest. The public impact was to dramatically change how Americans (both heterosexual and homosexual) viewed homosexuality. The consequences of removing the diagnosis from the APA's *DSM* for medicine and mental health was less dramatic. Patients continued to make requests (for both gay-affirming and sexual reorienting interventions) and treatments continued to be offered, regardless of diagnostic entity. Research into the origins of sexual

[8] Roes v. Wade is the 1973 U.S. Supreme Court care that legalized abortions throughout American.

orientation has also continued. Because of its impact on reducing social shame and facilitating social justice, the decision by the APA to remove homosexuality, although politically motivated, appears both socially beneficial and just, with a minimal down side for the medical profession. A few continue to question the rationale for the removal of homosexuality from the *DSM* when other orientations (paraphilias and fetishes) and gender disorders remain. Are these other groups (paraphilias, fetishes, and gender disorders) any less deserving of the positive social benefits that come from de-stigmatizing their sexuality, particularly those paraphilias that are 'victimless'? The question of how equipped medicine is for making these political and social decisions remains. Is it medicine's responsibility? Has society placed this within medicine's purview? It is clear that the issues cannot be settled by re-definition as if there were conclusive proof with which to solve an individual's problems.

Bioethical Analysis of the Professional Policies

A critical review of current professional policy statements articulated by the American Psychiatric Association, American Psychological Association, American Psychoanalytic Association, National Association of Social Workers, American Counselors' Association, American Pediatrics Association, and the American Association of Family Physicians reveals a strong emphasis on the principles of non-maleficence, justice, and autonomy (informed consent). The risk of harm manifest by anxiety, depression and suicide (non-maleficence) has been accused of being somewhat exaggerated in some professional statements. The issues of justice raised in these professional statements emphasize gay and lesbian social goals and perspectives and tend to ignore the role of religion in sexuality and the social status of non-lesbigays. Issues of autonomy focus almost exclusively on the provision of informed consent, including gay-affirming principles, while ignoring the issues of autonomy raised by a Western tradition of religious tolerance.

On final analysis it is clear that some of the professional organizations have come close to striking a bioethically balanced position statement (either intentionally or unintentionally). While other groups are more strongly attached to a goal of promoting a specific social or political agenda on behalf of a "group" within the culture at the ethical expense of others. It is clear that a policy could be engineered to be bioethically balanced if it recognized the diversity of values, views, and morality and at the same time placed the ultimate bioethical

responsibility with the patient and clinician instead of the professional organization or worse the legislature/judiciary. However, this is either not the goal of some organizations or to do so would undermine the primary political or social goal that has driven the development of a policy statement in the first place.

Engelhardt levels heavy criticism at any ethics consultant who seeks to represent his or her own bioethical vision as canonical. Likewise, I remain critical of any professional organization that reports to have developed an all-encompassing omni-applicable policy statement that relieves the patient and the clinician of any bioethical responsibility. The subject matter of sexual orientation and reorientation is too complex and the future technologies too obscure to adopt policy statements that are unable to evolve with the technology and the society or to be tailored to individual circumstances.

A Model Policy for Professional Organizations

First and foremost, a model professional policy or guideline statement would ideally address all four of the historically grounded, non-universal, co-equal principles that govern bioethics:

> "Beneficence (a group of norms for providing benefits and balancing benefits against risks and costs), non-maleficence (a norm for avoiding causing harm), autonomy (a norm representing the decision-making capacities of autonomous individuals) and justice (a group of norms for distributing benefits, risks, and costs fairly)" (Beauchamp & Childress, 1994, p.223).

Beauchamp and Childress suggest that most Westerners currently accept these principles as part of their common morality. That these principles are well accepted and readily understood by all, they provide a common language for the in-depth discussion described by Campbell and Higgs, and are readily accessible to individual clinicians and their patients.

Secondly, such a model would also consciously address each of the bioethical principles from the perspectives of both lesbigay and queer politics as well as that of conservative Christian fundamentalism, as both groups have strongly invested interests in the outcomes and consequences of such policies. Organized medicine and mental health have a fiduciary responsibility to both groups, as legitimate health care consumers.

Thirdly, such a model would fully acknowledge the cognitive skills and powers of judgment of the individual clinician in guiding the individual patient through the task of the adjudication of conflicts between two or more principles as they apply to his or her life situation and value system. There are no 'cookbook' answers; policies that suggest otherwise are naïve.

Lastly, such a model would acknowledge the current limitations and anticipate the future evolution of our understanding of the origins of human sexual orientation and sexual reorientation interventions. Otherwise, such a policy would rapidly become obsolete in an era of exponential biotechnological leaps.

The Campbell and Higgs model has revealed a number of discrepancies between the policy statements of various groups and illuminated some political agendas embedded in the policies. As the motivations of the authors of these policies come under scrutiny, the benefits of a model policy statement on sexual reorientation for all the professions become ever more clear.

On final analysis a postmodern bioethically sound policy statement applicable to any of the professional organizations would:

1. acknowledge the diversity of values and morality inherent in a multi-cultural religiously tolerant Western society,
2. highlight autonomy and beneficence as two primary principles for bioethical discussion,
3. acknowledge justice and non-maleficence as contributory principles for discussion and exploration, and
4. place the responsibility for this discussion and eventual bioethical resolution within the framework of clinician-patient relationship.
5. Be dynamic in allowing for change.

Two Principlist Models for the Individual Clinician

The struggle for the individual professional faced with resolving a clinical situation with conflicted and competing bioethical principles is loyalty to all of these premises. Whereas the Campbell and Higgs model for ethical exploration readily lends itself to group discussion and

collaboration on issues of policy, the following principlist models offer a focused and efficient route for the individual clinician struggling with the specifics of an individual case.

Not all principlists agree with Beauchamp and Childress (1996) that the principles of autonomy, non-maleficence, beneficence, and justice are, in the abstract, equal, and that therefore, in cases of conflict, the winning principle cannot be declared in advance of critical deliberations. Pellegrino (1993) argues that beneficence is the paramount principle in health care. It is his belief that health-care providers must remain focused on the patient's good or professional practice will degenerate. Pellegrino does not believe that autonomy and justice should play just as large a role in health care as beneficence and its correlate, non-maleficence, have traditionally played. He worries that too much autonomy is just as bad as too little, claiming that in the form of patients' rights and privacy, autonomy sometimes "overrides good medical judgment, encourages moral detachment on the part of the physician, and even works against the patients' best interests" (Pellegrino, 1993). Pelligrino also worries that, as inequities in the distribution of health care widen and anxieties about the cost of health care increase, appeals to justice may require physicians "to become agents primarily of fiscal or social purposes rather than the patient."

Pellegrino and Thomasma (1988) argue that conflicts in bioethics are not conflicts among the "four principles" but within the meaning of the patient's good. They describe the four components of the patient's total good as follows:

> The patient's first good is his ultimate good – vision, purpose, or being (e.g. God) that grounds the meaning of his existence. The patient's second good is his autonomy in general, the moral power that enables him to act as an independent decision-maker. The patient's third good is manifested in the particular decisions he makes. Depending on his fundamental values, it is up to him as an autonomous person to decide what kind of intervention he desires. The patient's fourth good is a very special one. It derives from the fact that, as a result of admittedly unfortunate circumstances, the patient has an opportunity to develop a particularly intimate relationship with his clinical provider. This bond has a long history and is rooted in the ends and goals of medicine: Can the healer make the patient well? If not, the healer should admit his limits (Pellegrino & Thomasma, 1993).

Of these four goods, the first, according to Pellegrino and Thomasma, is the one to which the other three must always defer. Thus, for example, if a provider believes that a homosexual in crisis about his sexual behavior should be referred for gay-affirming therapy,

but the patient does not want to submit to treatment because the quality of his religious life is more important to him than the quality of his sexual life, then the physician must defer to the patient's wishes. In short, the patient's beliefs about what ultimately makes life worth living must guide the provider's actions.

Pelligrino and Thomasma (1990) maintain that when principles conflict, beneficence must rule. Thus, in the case of the adolescent patient who seeks an intervention for an ego-dystonic sexual orientation, the good of the patient must remain paramount in discussing treatment. If the health provider believes that he can provide effective treatment of the adolescent in ways that offer more long-term benefits than burdens, then he should provide the treatment (beneficence). It should not matter if the adolescent's parents want to withhold it (autonomy). Nor does it matter if society wants to reduce homophobia and improve the social status of non-heterosexuals (justice).

In contrast to Pellegrino and Thomasma, Beauchamp and Childress (1996) offer a different way to handle the above case – a way that does not depend on automatically privileging the principle of beneficence but on developing W. D. Ross' rule for handling conflicts among principles. Ross (1930) proposes that when conflicting principles suggest different courses of action, people should perform the action that yields "the best balance of right over wrong." Beauchamp and Childress go a step further in suggesting that when one wishes to reject one principle in favor of another, not one but five requirements must be met:

- Better reasons can be offered to act on the overriding norm than on the infringed norm (for example, if persons have a *right*, their interests typically deserve a special place when balancing them against the interests of persons who have no comparable right).
- The moral objective justifying the infringement has a realistic prospect of achievement.
- No morally preferable alternative actions can be substituted.
- The form of infringement selected is the least possible, commensurate with achieving the primary goal of the action.
- The agent seeks to minimize the negative effects of the infringement.

Thus, following the Beauchamp and Childress model, if in the name of *justice* a physician decides to violate both *beneficence* and *autonomy* by not providing a referral to a sexual reorientation interventionist requested by a religiously conscientious adolescent patient, one must be relatively certain that: (1) the adolescent does not have a right to the intervention (incompetent by virtue of age or mental/emotional maturation); (2) homophobia (the moral objective to sexual reorientation interventions) will clearly be reduced in the community and

the social status of non-heterosexuals enhanced by withholding sexual reorientation intervention in this patient (justice will be well served); (3) gay-affirming therapy or other alternatives have been explored and are either contraindicated, unavailable, or competently declined; (4) nothing short of withholding sexual reorientation interventions will reduce homophobia in the community or enhance the social status of non-heterosexuals (only way to serve justice); (5) the physician must strive to resolve the crisis of sexual orientation while actively supporting the patient and parents.

The decision to use Pellegrino and Thomasma's model or the Beauchamp and Childress model is one for the individual clinician. Both scenarios provide a reasoned approach applicable to many clinical situations. Both are cognitively and conceptually accessible to practicing clinicians. Both are well grounded in a shared biomedical ethic accessible to discussion and collaboration by both philosophers and health professionals.

Despite the criticism of the inductivists and deductivists, principlists such as Beauchamp and Childress stress that their emphasis on principles, rules, obligations, and rights is not to be interpreted as a rejection of ethic's other elements. On the contrary, they embrace these other elements as crucial to the project of ethics:

> Often what counts most in moral life is not consistent adherence to principles and rules, but reliable character, moral good sense, and emotional responsiveness. Principles and rules cannot fully encompass what occurs when parents lovingly play with and nurture their children, or when physicians and nurses provide care and comfort. Our feelings and concern for others lead us to actions that cannot be reduced to the following of principles and rules (Beauchamp & Childress, 1996, p.181).

According to Beauchamp and Childress, the fact that principles are excellent tools to use in sorting through a moral dilemma does not mean that they are the *only* tools available. Nor does it mean that principles are the most important ingredient in a person's moral life. On the contrary, Beauchamp and Childress believe that the key to being moral "is a developed character that provides the inner motivation and strength to do what is right and good." To this end I have offered two models for the individual clinician to choose from, as both accommodate the moral professional. The model for professional organizations is provided as the avenue that leads the individual clinician to a bioethical model without a predetermined bioethical conclusion.

The Final Analysis

Since 1972, the mental health professions have been assessing and reassessing the status of non-heterosexuality in mental health. During the last three decades, homosexuality has been conceptualized as a disorder, a possible disorder (ego-dystonic homosexuality), and most recently, as neutral as it relates to the mental status of an individual (Rubenstein, 1995).

In the last decade there has been the emergence within the American mental health system of opposition to any form of clinical intervention to attempt a change of the sexual orientation from homosexual to heterosexual. Davison (1976), Martin (1984) and Haldeman (1994) are just few of those that have suggested that psychotherapeutic efforts to change sexual orientation are unethical. Opposition movements stress that reorientation interventions are ineffective and unethical. Professional organizations from mental health, family medicine, and pediatrics have passed resolutions to address these bioethical concerns.

If any conclusions can be drawn from the literature, it is that changes in sexual orientation are possible both independent of and following clinical interventions. Arguments from Martin (1984) and Haldeman (1994) that there are no empirical studies which support the idea that sexual reorientation interventions can produce desired changes, are lacking by virtue of omitting a number of significant reports and the failure to examine the outcomes of many studies which have demonstrated change (Throckmorton, 1998). Inconsistent rates of change are more likely related to lack of systematic research in this field, than to a hypothesized inability for humans to meaningfully change sexual orientation.

While some sexual reorientation providers believe homosexuality to be a developmental deficit, it clearly is not necessary to believe homosexuality is a disorder for the provider to offer intervention or for the patient to accept or benefit from the intervention. There are numerous elective medical and psychotherapeutic interventions routinely available for physical, mental and emotional states that are neither per se pathological nor problematic. In fact, the psychiatry, psychology and the counseling professions have traditionally held that one does not need to have a disorder in order to profit from psychotherapy or counseling. Clearly, if a client requests an intervention, offering it would not require the provider to view the patient as mentally ill.

All of the mental health professions in America have adopted language to require that the ethical practitioner should not discriminate against patients due to their sexual orientation. It

is notable that banning sexual reorientation interventions would require these same professionals to discriminate against those clients that want to change. Many clients that want to change their sexual orientation will likely meet the DSM criteria for *Sexual Disorder-Not Otherwise Specified* which includes several descriptors, one of which is "persistent and marked distress about sexual orientation" (ApA, 1994). A decision to actively discriminate against patients with a specific diagnosis seems clearly counter intuitive.

All of the mental health organizations have language that describes the ethical professional as one who "will actively attempt to understand the diverse cultural backgrounds of their patients." If professional organizations actively discredit sexual reorientation interventions, they may be implying that sexual arousal is more vital than any conflicting personality variable or moral conviction. Such a position is difficult to defend in a postmodern, culturally diverse society.

Thockmorton (1998) reminds counselors to be "aware of their own values, attitudes, beliefs, and behaviors and how these apply in a diverse society, and avoid imposing their values on patients." Thockmorton asks, what does it say to clients when sexual reorientation is opposed. To clients who want to explore the option for change, it means that their wish is diminished, *not to be taken seriously.* For individuals who are morally opposed to homosexuality as a lifestyle, it mean that the professions have *denigrated their moral convictions.* For the individuals who have successfully changed, it means that the professions *have criticized their accomplishments.* Referral to another provider is the most appropriate response for a professional who can not reconcile the patient's goals with their own skills and values.

Throckmorton shrewdly notes that while there has been a movement to oppose sexual reorientation, there has been no movement to avoid the disruption of an individual's religious convictions. Barret and Barzan (1996) write concerning spirituality and the gay experience that "assisting gay men and lesbians to step away from external religious authority may challenge the professional's own acceptance of religious teachings (p. 8). They suggest that "most professionals will benefit from a model that helps them understand the difference between spiritual and religious authority" (Barret and Barzan, 1996). I believe this subject and its bioethical implications has not been well explored by professional training.

I agree with Throckmorton (1998) who suggests that the opponents to sexual reorientation interventions must demonstrate that no patients have benefited from any procedures or that any benefits are too costly in some objective way to be pursued, even if they work. This burden of proof has not yet been met. Policies that limit patient access to desired care based on ethical grounds should always require similarly high standards, in the absence of rampant and profound social injustice.

Since the birth of bioethics, the field has struggled with the question of which is the superior ethical approach; one that applies overarching rules and guidelines to all ethical problems, or one that grants ethical leeway to decision makers based on their assessment of a specific problem (Tong, 1996). Professional organizations that generate policy statements are eager to apply overarching rules and promote guidelines that intentionally diminish the room for discussion between patient and professional and between professional peers. This path has proven ethically problematic.

In this scenario I agree with the principlists who believe it is the task of bioethicists to move between the principles and cases, sensitively calibrating them to each other in a way that is loyal to the moral history from which they both emerge (Tong, 1997). I believe that in today's complex health system serving culturally diverse populations each clinician must be able to function as a bioethicist with respect to his own patients and professional organizations must both acknowledge and emphasize that role for individual clinicians.

Although the principlists insist that the process is a rational one, inductivists stress that the idea of rationality, like all ideas, depends on culture for its ever-shifting meaning and that we cannot therefore eliminate moral intuitions from the realm of biomedical ethics. To that end, the patient must also be called to participate collaboratively in the role of his or her own bioethicist along with the clinician.

The past, present, and future of sexual reorientation interventions cannot be explored without encountering intensely debated philosophical, ethical, and bioethical dilemmas. The recent proliferation of policy statements and ethics guidelines from professional organizations on the subject of sexual reorientation interventions have not been received without some alarm and opposition within the mental health community. Again, we see a conflict between a collection of overarching rules and guidelines from professional groups to apply to all

sexual reorientation interventions versus a contextual decision-making process between the individual professional and individual patient.

On the surface, one can view these proclamations from organized medicine as well intended, well reasoned attempts to relieve individual professionals from the burden of contemplating these complex ethical issues on a case-by-case basis when they arise in the clinical setting. Another view suggests that these professional statements represent a form of social and political advocacy on the behalf of queer and lesbigay communities. Neither the public nor the professions have endowed these professional organizations with the role of "Societal Conscious" to be the arbiter of societal morality.

This thesis has explored the ways in which these proclamations by professional organizations are lacking in terms of uniformity and bioethical content and are suspicious in terms of motive. Recommendations to resolve these deficits have been offered. Following the principlist's tradition, this thesis also offers two models for the individual professional to tackle specific cases in clinical practice.

It is clear that sexual reorientation interventions have been and can continue to be offered within a bioethically and morally sound framework. Gay and lesbian groups have argued the interventions to be of no benefit (beneficence), potentially dangerous (non-maleficence), promoting homophobia and socially unjust (justice), and as a consequence incapable of being provided with informed consent (autonomy). Aside from the issue of coercion with teens and children, none the arguments hold up under scrutiny.

It is clear that professional organizations are ill prepared to weather the bioethical storm that follows attempts to generate one overarching omni-applicable policy on sexual reorientation. It is also clear that any policy generated will be at any given time ahead of the discussion in some communities and lagging behind the discussion in other communities, and forever ill prepared to deal with evolving biotechnologies. When forced to generate a policy, these organizations must address the needs and interests of all parties on both sides of the debate and always place the responsibility for resolving bioethical issues in the lap of the individual professional and the specific patient.

It is also clear that professional organizations must acknowledge that there is rarely one right answer for every patient or every community. The exception being that interventions that are coercive must always be avoided. There are no instances where sexual reorientation

can be viewed as an emergency life-saving intervention, which means full informed consent is always required. It is clear that for any currently available treatment to be effective, it requires the willing participation of the patient. It is my strong view that until there is clear and convincing evidence of uniform safety and efficacy with children and adolescents, no treatments should be performed on under age patients without the minor's express and clearly not coerced endorsement.

The principles of beneficence and non-maleficence are shown to be critical issues for resolution by the individual professional and his or her patient to accomplish informed consent. Are there legitimate benefits experienced by some patients following a course of sexual reorientation intervention? Absolutely, there are. Can these potential benefits outweigh the risks to social justice and risk for short-term and long-term harm? Absolutely, they can. Are there risks associated with gay affirming therapies? Absolutely, there can be. Are there benefits associated with gay affirming therapies? Absolutely, there can be. What is the social impact of gay affirming therapies on community morality or religiosity? Little or none, I believe. What is the social impact of sexual reorientation therapies on the progress of the gay, lesbian and bisexual social movement? Little or none, I believe. Is there one right answer in a postmodern world? No.

It is my view of the medical tradition, that every clinical professional has a responsibility to their patient to bioethically reason through the specific individual issues raised on a case-by-case basis, and that no amount of professional guidelines and policy statements from organized medicine can relieve the practitioner of that responsibility. To this end, this thesis has illuminated the process without dictating the outcome for the individual patient and in the process resolved the bioethical questions raised at the beginning of this analysis.

References

Leviticus 20:13.

(1968). Family law reform act (8(1) ed.). London: Judiciary Press.

(1986). Gillick v. West Norfolf and Wisbech. In (Ed.), A.C. (p. 112). London: H.L.

Results of poll. (1989, June 6). San Francisco Examiner, p. A19.

ACSF (Analyse Des Comportements Sexuels En France) Investigators (1992). AIDS and sexual behavior in France. Nature, 360, 407-409.

Adam, B. D. (1986). Age, structure, and sexuality: reflections on the anthropological evidence on homosexual relations. In Blackwood, E. (Ed.), Anthropology and homosexuality (pp. 19-34). New York: Haworth.

Adams, H. E., Sturgis, E. T. (1977). Status of behavioral reorientation techniques in the modification of homosexuality: a review. Psychological Bulletin, 84, 1171-1188.

Adams, H., Wright, L., Lohr, B. (1996). Is homophobia associated with homosexual arousal? Journal of Abnormal Psychology, 105, 440-445.

Adler, A. (1930). The problem with homosexuality. Zeitschrift der Individualpsychologie, 1(1), 1-10.

Alcock, J. (1984). An evolutionary approach. SunderJand, MA: Sinauer Associates.

Almaquer, T. (1991). Chicano men: a cartography of homosexual identity and behavior. Difference, 3, 75-100.

Alonso, A. M., Koreck, M. T.. (1989). Silences: "hispanics", AIDS, and sexual partners. Differences, 1, 101-124.

Altman, D. (1971). Homosexual oppression and liberation. New York: NYU Press.

Altman, D. (1982). The homosexualization of America. Boston, MA: Beacon Press.

Altman, D., Vance, C., Vicinus, M. (1989). Homosexuality, which homosexuality? London: GMP Publishers.

American Academy Family Physicians (May 10). AAFP recommendations: treatment of homosexuality in children and adolescents is contraindicated. Retrieved June 12, 2000 from the World Wide Web: http://aafp.org/serlet/xmlPress?action=list212

American Academy Of Family Physicians (1993, Dec). Policy statement: adolescent sexuality. American Journal of Family Practice, 35, 1532.

American Academy Of Pediatrics (1993, Oct). Policy statement, "homosexuality and adolescence". Pediatrics, 29, 221.

American Counseling Association (April10). Position statement on treatment of sexual orientation. Retrieved June 15, 2001 from the World Wide Web: http://www.counseling.org/multi_diversity/

American Psychiatric Association (1952). Diagnostic and statistical manual of mental disorders. Washington, DC: American Psychiatric Press.

American Psychiatric Association (September 1994). Fact Sheet - September 1994. Retrieved Dec 30, 2001 from the World Wide Web:

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, Fourth edition. Washington, DC: American Psychiatric Press.

American Psychiatric Association (January 15, 1998). APA maintains reparative therapy not effective. Retrieved Jan 2, 2002 from the World Wide Web: http://www.psych.org/

American Psychological Association (June 1990). Fact sheet on homosexuality. Retrieved December 30, 2001 from the World Wide Web: http://apa.org/pubinfo/orient.html

American Psychological Association (Aug 14, 1998). Resolution on appropriate therapeutic responses to sexual orientation. Retrieved January 1, 2002 from the World Wide Web: http://www.hrc.org/feature2/apares.html

American Psychological Association (2001). APA online: public interest: just the facts about sexual orientation and youth: a primer for principals, educators and school personnel. Retrieved Dec 30, 2001 from the World Wide Web: http://www.apa.org/pi/lgbc/publications/justthefacts.html

Amnesty International French Medical Commission & Valerie Marange (1991). Doctors and torture: collaboration or resistance. London: Bellew Publishing.

Anonymous (1997, Jan 23). Letters to the editor: homosexuality doesn't need a "cure". Wall Street Journal, p. 26.

Arndt, J. L. (1961). A contribution to the understanding of homosexuality. Geneeskundige Bladen, 3, 65-105.

Bailey, D. S. (1955). Homosexuality and the Western Christian tradition. London: Longmans, Green & Co.

Bailey, J. M., Pillard, R. C. (1991, December 17,). Are some people born gay? The New York Times, p. A19.

Bailey, J. M., Zucker, K. J., (1995). Childhood sex-typed behavior and sexual orientation: a conceptual analysis and quantitative review. Developmental Psychology31(1):43-55.

Barlow, D. H., Leitenberg, H., Agras, W. S. (1969). Experimental control of sexual deviations through manipulation of the noxious scene in covert sensitization. Journal of Abnormal Psychology, 74, 596-601.

Barret, R., Barzan, R. (1996). Spiritual experiences of gay men and lesbians. Counseling and Values, 41, 4-15.

Bateson, G. (1936). Naven. Cambridge: Cambridge Press.

Bayer, R. (1981). Homosexuality and American psychiatry: the politics of diagnosis. New York: Basic Books.

Bayer, R. (1987). Homosexuality and American psychiatry, the politics of diagnosis (2nd ed.). Princeton: Princeton University Press.

Beauchamp, T. L., Childress, J. F. (1994). Principles of Biomedical Ethics (4th ed.). New York: Oxford University Press.

Bell, A. P., Weinberg, M. S., Hammersmith, S. K. (1981). Sexual preference: its development in men and women. Bloominton, IN: Indiana University Press.

Berger, P., Luckmann, T. (1966). The social constructions of reality. Garden City, NY: Doubleday.

Bergin, A. (1980). Psychotherapy and religious values. Journal of Consulting Clinical Psychology, 48, 323-338.

Bergler, E. (1957). Homosexuality: disease or way of life. New York: Hill & Wang.

Berrill, K. T. (1992). Antigay violence and victimization in the United States: an overview. In G. M. Herek, K. T. Berrill (Ed.), Hate crimes: confronting violence against lesbians and gay men. (pp. 19-45). Newbury Park, CA: Sage.

Bieber, I. (1962). Homosexuality: a psychoanalytic study of male homosexuals. New York: Basic Books.

Bieber, I. (1967). Homosexuality. In Alfred Freeman & Harold Kaplan (Eds.), Comprehensive textbook of psychiatry (p. 973). Baltimore, MD: Williams & Watkins.

Bieber, I., Dain, H. J., Dince, P. R. (1962). Homosexuality: a psychoanalytic study. New York: Basic Books.

Billy, J. O. G., Tanfer, K., Grady, W. R. (1993). The sexual behavior of men in the United States. Family Planning Perspectives, 25, 52-60.

Bilu, Y., Witztum, E. (1994). Culturally sensitive therapy with ultra-orthodox patients: the strategic employment of religious idioms of distress. Israel Journal of Psychiatry, 31, 170-182.

Binstock, T. (2001). An immune hypothesis of sexual orientation. Medical Hypotheses, 57(5), 583-590.

Birk, L. (1974). Group psychotherapy for men who are homosexual. Journal of Sex and Marital Therapy, 1, 29-52.

Blackwood, E. (Ed.). (1986). Anthropology and homosexual behavior. New York: Haworth.

Boswell, J. (1980). Christianity, social tolerance and homosexuality. Chicago: University Of Chicago Press.

Boswell, J. (1980). Christianity, social tolerance, and homosexuality: gay people in western Europe from the beginning of the Christian era to the fourteenth century. Chicago: University Chicago Press.

Boswell, J. (1992). Christianity, social tolerance, and homosexuality. Chicago: University Of Chicago Press.

Boswell, J. (Ed.). (1992). Same-sex unions in pre-modern Europe. New York: Villard.

Boswell, J. (1994). Same sex unions in pre-modern Europe. New York: Villard Books.

Boucek, F. (1991). Shame and the self. New York: Guilford Press.

Bowder, D. (1982). Who was who in the Greek world. New York: Cornell University Press.

Boyd, K., Higgs, R., Pinching, A. (Ed.). (1997). The new dictionary of medical ethics. London: BMJ Publishing Group.

Bracken, P., Thomas, P. (2001). Post-psychiatry: a new direction for mental health. British Medical Journal, 322, 724-727.

Bray. A. (1988). Homosexuality in renaissance England. London: Gay Men's Press.

Brierley, M. (1932). Some problems of integration in women. International Journal of Psychoanalysis, 13, 433-448.

British Broadcast Company (May 12). Reproductive technology in the news. Retrieved December 21, 2001 from the World Wide Web: http://news.bbc.co.uk/hi/english.sci.tech.default.stm

British Medical Association Working Party On Torture (1992). Medicine betrayed: the participation of doctors in human rights abuses. London: BMJ Publishing.

Broucek, F.J. (1982). Shame and its relationship to early narcissistic developments. International Journal of Psychoanalysis, 63(3), 369-378.

Bullough, V. L. (1974). Homosexuality and the medical model. Journal of Homosexuality, 22, 99-110.

Burch, B. (1986). Psychotherapy and the dynamics of merger in lesbian couples. In T. Stein & C. Cohen (Eds.), Contemporary perspectives on psychotherapy with lesbians and gay men (pp. 57-73). New York: Plenum.

Butler, J. (1990). Gender trouble. New York: Routledge.

Butler, J. (1990). Gender trouble: feminism and the subversion of identity. New York: Routledge.

Butler, J. (1993). Critically queer. Journal of Gay and Lesbian Studies, 1(1), 17-32.

Byne, W. (1996). Biology and homosexuality: implications of neuroendocrinological and neuranatomical studies. In Robert P. Cabaj & Terry S. Stein (Eds.), Textbook of homosexuality and mental health (pp. 129-145). Washington, DC: American Psychiatric Press.

Byne, W., Parson, B. (1993). Sexual orientation: the biological theories reappraised. Archives of General Psychiatry, 50, 228-239.

Calahan, D. (1997). History of bioethics. In Boyd, K.M., Higgs, R., Pinching, A.J. (Ed.), The new dictionary of medical ethics (p. 23). London: BMJ Publishing.

Campbell, A., Higgs, R. (1982). In that case: medical ethics in everyday practice. London: Darton Longman & Todd.

Carnes, P. (1983). Out of the shadows: understanding sexual addiction. Minneapolis: Comp-Care Publications.

Carrier, J. M. (1980). Homosexual behavior in cross-cultural perspective. In J. Marmor (Ed.), Homosexual behavior: a modern reappraisal (pp. 100-122). New York: Basic Books.

Carrier, J.A., Coates, T.J., Stall, R. (Ed.). (1980). Homosexual behavior in cross-cultural perspective, in homosexual behavior: a modern reappraisal. New York: Basic Books.

Carrol,T. K. (1996). A critical look at theories of gay male identity development. Berkeley, CA : Wright Institute Press.

Cass, V. C. (1983). Homosexual identity: a concept in need of definition. Journal of Homosexuality, 9, 105-126.

Cass, V.C. (1979). Homosexual identity formation: a theoretical model. Journal of Homosexuality, 4, 219-235.

Cass, V.C. (1985). Homosexual identity: a concept in need of definition. Journal of Homosexuality, 9(2-3), 105-126.

Castle, T., (1993). The apparitional lesbian: female homosexuality and modern culture. New York: Columbia University Press.

Catania, G., Coates, T.J., Stall, R. (1992). Prevalence of AIDS-related risk factors and condom use in the United States. Science, 258, 1101-1106.

Cautela J. (1967). Covert sensitization. Psychological Rep, 20, 459-468.

Chauncey, G. (1994). Gay New York: gender, urban culture, and the making of the gay male world, 1890-1940. New York: Basic Books.

Chinese Psychiatric Association (June). Shifting gears on homosexuality. Retrieved March 8, 2001 from the World Wide Web: http://abcnews.go.com/sections/world/DailyNews/china010307.html

Clouser, K. D., Gert, B. (1990). A critique of principlism. Journal of Medicine and Philosophy, 15(2), 235.

Cochran, W. G., Mosteller, F., Tukey, J. W. (1954). Statistical problems of the Kinsey report on sexual behavior in the human male. Washington, DC: American Statistical Association.

Coleman, E. (1981). Developmental stages of the coming out process. Journal of Homosexuality, 7, 31-44.

Coleman, E. (1982). Developmental stages of the coming-out process. In J. Gonsiorek (Ed.), Homosexuality adn psychotherapy: a practitioner's handbook of affirmative models (pp. 31-44). New York: Haworth.

Crain, C. (1999, Aug). Did a germ make you gay?. Out Magazine, 35, 46-49.

Crapanzano, V. (1973). The Hamadasha: a study in Moroccan ethno-psychiatry. Berkeley: University Of California Press.

D'Emilio, J. (1986). Making and unmaking minorities: the tension between gay politics and history. New York University Review of Lay and Social Change, 14, 915-922.

Dank, B. (1971). Coming out in the gay world. Psychiatry, 34, 180-197.

Davison, G. C. (1968). Elimination of a sadistic fantasy by a client-controlled counter-conditioning technique. Journal of Abnormal Psychology, 44, 157-162.

Davison, G.C. (1976). Homosexuality: the ethical challenge. Journal of Clinical Psychology, 44, 157-162.

DeCecco, J. P. (1981). Definition and meaning of sexual orientation. Journal of Homosexuality, 6, 51-59.

DeCecco, J. P., Shively, M. G. (1983). From sexual identity to sexual relationships: a contextual shift. Journal of Homosexuality, 9(2/3), 1-26.

Deleuze, G. (1962). Nietzsche and philosophy. In H. Tomlinson, Trans (Ed.), Nietzsche and philosophy (p.). New York: Columbia Press.

Deutsch, H. (1948). On female homosexuality. In R. Fleiss (Ed.), The psychoanalytic reappraisals of sexual identities (pp. 208-230). Madison, CT: International Universities Press.

Devereaux, G. (1937). Institutionalized homosexuality of the Mohave Indians. Human Biology, 9, 498-527.

Devlin, P. K., Cowan, G. A. (1985). Homophobia, perceived fathering, and male intimate relationships. Journal of Personality Assessment, 49, 467-473.

Dollimore, J. (1991). Sexual dissidence. Oxford: Clarendon Press.

Donn, J. (2000, March 29). Finger length linked to sexual orientation: male hormones in womb produce differences: study. Associated Press, p. 1.

Dorner, G., Geier, T. Ahrens, L., Krell, G. Munx, H., Sieler, E., Muller, H. (1980). Prenatal stress as possible aetiological factor of homosexuality in human males. Endokrinologie (Leipzig), 75, 365-368.

Dover, K. (1978). Greek homosexuality. Cambridge, MA: Harvard University Press.

Drescher, J. (Jan). Letters to the editor of Psychiatric News. Retrieved 12/21/2001 from the World Wide Web: http://www.psych.org

Dubois, P. (1982). Sowing the body. Chicago: University Of Chicago Press.

Durner, G. (1983). Letter to the editor. Archives of Sexual Behavior, 12, 577-582.

Durner, G., Gotz, F., Rohde, W. (1987). Sexual differentiation of gonadotropin secretion, sexual orientation, and gender role behavior. Journal of Steroid Biochemistry, 27, 1081-1087.

Dynes, W. R., Johansson, W., Percy, W. A. (Ed.). (1990). Encyclopedia of homosexuality. New York: Garland Publishing.

Ehrhardt, A. A., Meyer-Bahlburg, H. F. L. (1991). Effects of prenatal sex hormones on gender-related behavior. Science, 211, 1312-1318.

Eidelberg, L. (1956). Analysis of a case of male homosexuality. In S. Lorand & M. Balint (Eds.), Perversions (p.). London: Gramercy Books.

Eisenbud, R. J. (1982). Early and later determinants of lesbian choice. Psychoanalytic Review, 69, 85-109.

Ellis, A. (1956). Effectiveness of psychotherapy with individuals who have severe homosexual problems. Journal of Consulting Psychology, 20, 191-195.

Ellis, H. (1922). Studies in the psychology of sex (vol II), sexual inversion. Philadelphia: FA Davis.

Ellis, H. (1922). Studies in the psychology of sex, volume II: sexual inversion. Philadelphia: FA Davis.

Engelhardt, T. (1996). The foundations of bioethics. New York: Oxford University Press.

Epstein, S. (1987). Gay politics, ethnic identity: the limits of social constructionism. Socialist Review, 93/94, 9-54.

Erikson, E. H., (1959). Identity and the life cycle. Psychological Issues, 1:1-171.

Erikson, E. H., (1968). Identity: youth and crisis. London: Faber & Faber.

Fagot, B., Leinback, M. (1993). Gender role development in young children: from discrimination to labeling. Developmental Review, 13(2), 205-224.

Fast, I. (1984). Gender identity: a differentiation model. Hillsdale, NJ: Erlbaum Press.

Feldman, M. P., MacCulloch, M. J. (1971). Homosexual behavior: therapy and assessment. New York: Pergamon Press.

Feldman, P. (1977). Helping homosexuals with problems: a commentary and a personal view. Journal of Homosexuality, 2, 241-250.

Fenichel, O. (1945). The psychoanalytic theory of neurosis. New York, NY: Norton.

Fensterheim, H. (1972). The initial interview. In A. A. Lazarus (Ed.), Clinical behavior therapy (pp. 22-40). New York: Brunner-Mazel.

Ferenczi, S. (1914). The nosology of male homosexuality - homoeroticism. In S. Ferenczi (Ed.), Contributions to psychoanalysis. New York: Brunner-Mazel.

Fletcher, J. (1954). Morals and medicine: bioethics. New York: Basic Books.

Ford, C. S., Beach, F. A. (1951). Patterns of sexual behavior. New York: Harper.

Foucault, M. (1978). The history of sexuality (R. Hurley, Trans.). New York: Random House.

Foucault, M. (Ed.). (1986). The history of sexuality, vol 1: an introduction. New York: Hurley.

Fox, R. C. (1996). Bisexuality: an examination of theory and research. In Robert P. Cabaj & Terry S. Stein (Eds.), Textbook of homosexuality and mental health (pp. 147-171). Washington, DC: American Psychiatric Press.

Fradenburg, L.O., Freccero, C. (1995). The pleasures of history. Gay and Lesbian Quarterly, 1(4), 371-384.

Frankl, V. (1975). Paradoxical intention and de-reflection. Psychotherapy: Theory, Research and Practice, 12, 226-237.

Freud, A. (1949). Some clinical remarks concerning the treatment of male homosexuality. The International Journal of Psychoanalysis, 30, 195.

Freud, A. (1952). Studies in passivity: notes on homosexuality. In Anna Freud (Ed.), The writings of Anna Freud: indications for child analysis and other papers (pp. 205-214). New York: International Universities Press.

Freud, S. (1922). Certain neurotic mechanisms in jealousy. In Sigmund Freud (Ed.), Paranoia and homosexuality (p. 168). New York: Collier Books.

Freud, S. (1953). The interpretation of dreams (1900). In J. Strachey (Translated) (Ed.), Standard edition of the complete psychological works of Sigmund Freud, vol 7. London: Hogarth Press.

Freud, S. (1955). Psychogenesis of a case of homosexuality in a woman (1920). In J. Strachey (Translated) (Ed.), The standard edition of the complete psychological works of Sigmund Freud, (vol 18) (pp. 145-172). London: Hogarth Press.

Freud, S. (1955). Some neurotic mechanism in jealousy, paranoia and homosexuality (1922). In J. Strachey (Ed.), Standard edition of the complete psychological works of Sigmund Freud, vol 19 (pp. 223-232). London: Hogarth Press.

Freud, S. (1957). A letter to an American mother. In Ernest Jones (Ed.), The life and work of Sigmund Freud, Vol 3, the last phase: 1919-1939 (pp. 195-196). New York: Basic Books.

Freud, S. (Ed.)(1962). Three essays on the theory of sexuality (1905). New York: Basic Books.

Freud, S. (1963). Psychoanalytic notes upon an autobiographical account of paranoia. In Sigmund Freud (Ed.), Three case histories (p. 164). New York, NY: Collier Books.

Freud, S. (1970). A child is being beaten. In Sigmund Freud (Ed.), Sexuality and the psychology of love (p. 131). New York: Collier Books.

Freud, S. (1971). The psychogenesis of a case of homosexuality in a woman. In S. Freud & O. Rank (Eds.), Sexuality and the psychology of love (p. 145). New York: Collier Books.

Freud, S. (1971). The sexual enlightenment of children. In S. Freud & O. Rank (Eds.), Analysis of a phobia in a five year old boy (1909) (p. 146). New York: Collier Books.

Freud, S., Rank, O. (1922, January 22). Letter. Body Politic, 9.

Freud, S., Rank, O. (1977). Circular letter. In (Ed.), Body Politic (p. 9). Chicago: Chicago Press.

Freund, K. W., Sedlacek, F., Knob, K. (1965). A simple transducer for mechanical plethysmography of the male genital. Journal of the Experimental Analysis of Behavior, 8, 169-170.

Freund, K.W. (1974). Male homosexuality: an analysis of the pattern. In J.A. Lorraine (Ed.), Understanding homosexuality: its biological and psychological bases (pp. 25-81). New York: Elsevier.

Friedman, R. C., Downey, J. (1993). Neurobiology and sexual orientation: current relationships. Journal of Neuropsychiatry and Clinical Neuroscience, 5, 131-153.

Gagnon, J. H., Simon, W. (1973). Sexual conduct: the social sources of human sexuality. Chicago: Aldine.

Gebhard, P. H. (1972). Incidence of overt homosexuality in the United States and western Europe, in National Institute of Mental Health task force on homosexuality: final report and background papers. Rockville, MD: National Institute Of Mental Health.

Gebhard, P. H., Johnson, A. B. (1979). The Kinsey data: marginal tabulations of the 1938-1963 interviews conducted by the Institute of Sex Research. Philadelphia: WB Saunders.

Gergen, K., Davis, K. (Ed.)(1985). The social construction of the person. New York: Springer.

Goldberg, J. (Ed.)(1995). Queering the renaissance. Durham: Duke.

Goldberg, J. (1995). The history that will be. Gay and Lesbian Quarterly, 1(4), 385-403.

Gooren, L. (1990). Biomedical theories of sexual orientation: a critical examination. In D.P. McWhirter, S.A. Sanders, J.M. Reinisch (Ed.), Homosexuality / heterosexuality: concepts of sexual orientation (pp. 71-87). New York: Oxford University Press.

Gorski, R. A., Gordon, J. H., Shryne, J. E. (1978). Evidence for a morphological sex difference within the medial pre-optic area of the rat brain. Brain Research, 148, 333-346.

Gough, K. (1975). The origins of the family. In R. Reiter (Ed.), Toward an anthropology of women (pp. 51-76). New York: Monthly Review Press.

Goy, R. W., McEwan, B. S. (1980). Sexual differentiation of the brain. Cambridge, MA: MIT Press.

Great Britain Committee On Homosexual Offenses And Prostitution (1963). The Wolfenden report (USA ed.). New York: Stein & Day.

Green, R. (1974, April 3). Letter to the editor. Psychiatric news, 1, 2.

Green, R. (1987). The sissy boy syndrome and the development of homosexuality. New Haven: Yale University Press.

Green, R., Stroller, R. J. (1971). Two monozygotic (identical) twin pairs discordant for gender identity. Archive of Sexual Behavior, 1, 321-327.

Greenberg, D. (1988). The construction of homosexuality. Chicago: University Of Chicago Press.

Greenberg, D. F., Byrstryn, M. H. (1984). Capitalism, bureaucracy, and male homosexuality. Contemporary Crisis, 8, 33-56.

Greenberg, J. (1991). Oedipus and beyond. Cambridge: Harvard University Press.

Greene, B. (1994). Lesbian and gay sexual orientations. In B. Greene & G. Herek (Eds.), Lesbian and gay psychology (pp. 1-24). Thousand Oaks: Sage Publications.

Gundlach, R. H., Reiss, B. F., (1968). Self and sexual identity. In: B. F. Reiss (Ed.), New directions in mental health. New York: Grune & Stratton.

Haldeman, D. C. (1994). The practice and ethics of sexual orientation conversion therapy. Journal of Consulting Clinical Psychology, 62, 221-227.

Hall, J. A. Y., Kimura, D. (1994). Dermatoglyphic asymmetry and sexual orientation in men. Behavioral Neuroscience, 108(6), 1203-1206.

Hall, M. (1987). Sex therapy with lesbian couples: a four stage approach. In E. Coleman (Ed.), Psychotherapy with homosexual men and women: integrated identity approaches for clinical practice (pp. 137-156). New York: Hogarth Press.

Halley, J. E., (1994). Sexual orientation and the politics of biology: a critique of the argument from immutability. Stanford Law Review Feb. 1994, 46(3): 527n94, 560n229.

Halperin, D. (1990). One hundred years of homosexuality. New York: Routledge.

Halperin, D. (1990). One hundred years of homosexuality and other essays on Greek love. Boston: Routledge.

Halperin, D. (1995). Saint = Foucault. New York: Oxford Press.

Halperin, D., Winkler, J., Zeitlin, F. (Ed.). (1990). Before Sexuality. Princeton: Princeton University Press.

Hamer, H. D., Hu, S., Magnuson, V. L. (1993). A linkage between DNA markers on the X chromosome and male sexual orientation. Science, 261, 321-327.

Hamilton, E., Cairns, H. (Ed.). (1961). Symposium, in Plato: the collected dialogues. Princeton, NJ: Princeton University Press.

Hammersmith, S. K., Weinberg, M. S. (1973). Homosexual identity: commitment, adjustment, and significant others. Sociometry, 36, 56-79.

Harris, T. A. (1973). I'm okay, you're okay. London: Pan Books.

Harry, J. (1982). Gay children grown up: gender culture and gender deviance. New York: Praeger.

Hart, J. (1984). Therapeutic implications of viewing sexual identity in terms of essentialist and constructionist theories. Journal of Homosexuality, 9(4), 39-51.

Hart, J., Richardson, D. (Ed.).(1981). The theory and practice of homosexuality. Boston: Routledge.

Hatterer, L. (1970). Changing the homosexual male. New York: McGraw Hill.

Hatterer, L. J. (1980). The pleasure addicts. South Brunswick, NY: Barnes & Yoseloff.

Heath, R. G. (1972). Pleasure and brain activity in man. Journal of Nervous Mental Disease, 154, 3-18.

Heilman, S.C., Witztum, E. (1997). Value sensitive therapy: learning from ultra-orthodox patients. American Journal of Psychotherapy, 51(4), 522-541.

Hencken, J. D. (1982). Homosexuality and psychoanalysis: toward a mutual understanding. In W. Paul & J. D. Weinrich (Eds.), Homosexuality: research implications for public policy (p. 12). Newbury Park, CA: Sage.

Henry, G. W. (1941). Sex variants: a study of homosexual patterns. New York: Paul B. Hoeber.

Herdt, G. (1981). Guardians of the flutes: idioms of masculinity. New York: McGraw-Hill.

Herdt, G. (1982). Fetish and fantasy in Sambia initiation. In G. Herdt (Ed.), Rituals of manhood: male initiation in Papua, New Guinea (pp. 48-98). Berkeley: University Of California Press.

Herdt, G. (1983). Bisexuality and homosexual identity: critical theoretical issues. Journal of Homosexuality, 10, 53-62.

Herdt, G. (1984). Ritualized homosexuality in Melanesia. Berkeley: University Of California Press.

Herdt, G. (1987). Homosexuality. In G. Herdt (Ed.), Encyclopedia of religion (pp. 35-57). New York: MacMillian.

Herdt, G. (1987). The Sambia: ritual and gender in New Guinea. New York: MacMillan.

Herdt, G. (1988). Cross cultural forms of homosexuality and the concept "gay". Psychiatric Annals, 18, 37039.

Herdt, G. (1989). Introduction: gay youth, emergent identity, and cultural sense at home and abroad. In Herdt, G. (Ed.), Homosexuality and adolescence (p.). New York: Herrington Press.

Herdt, G. (1993). Ritualized homosexual behavior in the male cults of Melanesia, 1862-1983: an introduction, in ritualized homosexuality in Melanesia (2nd ed.). Berkeley: University of California Press.

Herdt, G. (1994). Third sex, third gender: beyond sexual dimorphism in culture and history. New York: Zone Books.

Herdt, G. H. (1992). Gay culture in America: essays from the field. Boston: Beacon Press.

Herdt, G., Boxer, A. (1993). Children of horizons. Boston: Beacon Press.

Herek, G. M. (1984). Beyond "homophobia": a social psychological perspective on attitudes towards lesbians and gay men. Journal of Homosexuality, 10, 1-21.

Herek, G. M. (1984). Beyond "homophobia": a social psychological perspective on attitudes towards lesbians and gay men. Journal of Homosexuality, 10, 1-21.

Herek, G. M. (1990). The context of anti-gay violence: notes on cultural and psychological heterosexism. Journal of Interpersonal Violence, 5, 316-333.

Herek, G. M. (1991). Stigma, prejudice, and violence against lesbians and gay men. In J. Gonsiorek, J. Weinrich (Ed.), Homosexuality: research implications for public policy (pp. 60-88). Newbury Park, CA: Sage.

Herek, G. M. (1992). Psychological heterosexism and antigay violence: the social psychology of bigotry and bashing. In J. Gionsiorek, J. Weinrich (Ed.), Hate Crimes: Confronting Violence Against Lesbians and Gay Men (pp. 60-80). Newbury Park, CA: Sage.

Herek, G. M. (1994). Assessing attitudes towards lesbians and gay men: a review of empirical research with the ATLG scale. In B. Greene, G.M. Herek (Ed.), Lesbian and gay psychology: theory, research, and clinical applications (pp. 149-169). Newbury Park, CA: Sage.

Herek, G. M. (1996). Heterosexism and homophobia. In R.P. Cabaj, T. S. Stein (Ed.), Textbook of homosexuality and mental health (pp. 101-111). Washington, DC: American Psychiatric Press.

Herek, G. M., Capitano, J. P. (1995). Black heterosexuals' attitudes toward lesbians and gay men in the United States. The Journal of Sex Research, 32, 95-105.

Herek, G. M., Glunt, E. K. (1993). Interpersonal contact and heterosexual's attitudes toward gay men: results from a national survey. The Journal of Sex Research, 30, 239-244.

Hetrick, E., Martin, A. D. (1987). Developmental issues and their resolution for gay and lesbian adolescents. In E. Coleman (Ed.), Psychotherapy with homosexual men and women: integrated identity approaches for clinical practice (pp. 25-44). New York: Haworth.

Higgs, R. (1997). Methods of ethical debates. In K. M. Boyd, R. Higgs, A.J. Pinching (Ed.), The new dictionary of medical ethics (p. 87). London: BMJ Publishing.

Highwater, J. (1990). Myth and sexuality. New York: Meridian.

Hirschfeld, M. (1871). Sexual pathology: a study of derangements of the sexual instinct. New York: Emerson.

Hirschfeld, M. (1936). Homosexuality. In I. Bloch, M. Hirschfield (Ed.), Encyclopedia Sexualis (pp. 321-334). New York: Dingwall-Rock.

Hocquenghem, G. (1978). In D. Dangoor (Trans) (Ed.), Homosexual desire. Durham: Duke University Press.

Hoffman, J. (1968). The psychodynamics of a nonmoralistic morality. Ethical Confrontation in Counseling, pp.90-111. New York: Blackwell.

Hoffman, R. J. (1983). Vices, gods, and virtues: cosmology as a mediating factor in attitude toward male homosexuality. Journal of Homosexuality, 9(2/3), 244-270.

Holmes, R. (1990). What is applied about philosophy. In K. Danner Clouser & Lorettta Kopelman (Eds.), Journal of Medicine and Philosophy (p. 123). 15: 2.

Hood, R. W., Spilka, B., Hunsberger, B. Gorsuch, R. (1996). The psychology of religion: an empirical approach (2nd ed.). New York: The Guilford Press.

Hooker, E. (1965). An empirical study of some relations between sexual patterns and gender identity in male homosexuals. In J. Money (Ed.), Sex research: new developments (pp. 24-52). New York: Holt, Reinhart & Winston.

Horney, K. (1950). Neurosis and inner growth. New York: Norton.

Hoy, D., McCarthy, T. (1994). Critical theory. Cambridge: Blackwell.

Hutchinson, G. E. (1981). A speculative consideration of certain possible forms of sexual selection in man. American Naturalist, 93, 81-91.

Institute Of Medicine (1986). Confronting AIDS: directions for public health, healthcare, and research. Washington, DC: National Academy Press.

Irigaray, L. (1985). In C. Porter (Trans.) (Ed.), This sex which is not one (p.83). Ithaca: Cornell University Press.

Isay, R. (1985). On the analytic therapy of homosexual men. Psychoanalytic Studies of Children, 40, 235-254.

Isay, R. (1989). Being homosexual: gay men and their development. New York: Avon Press.

Jagose, A. (1996). Queer theory: an introduction. New York: NYU Press.

Jefferson, D. J. (1993, August 12,). Science besieged: studying the biology of sexual orientation has political fallout. The Wall Street Journal, p. A1.

Johnsgard, K. W., Schumacher, R. M. (1970). The experience of intimacy in group psychotherapy with male homosexuals. Psychotherapy: Research and Practice, 7, 173-176.

Johnson, A. M., Wadsworth, J., Wellings, K. (1992). Sexual lifestyles and HIV risk. Nature, 360, 410-412.

Jones, E. (1927). The early development of female sexuality. International Journal of Psychoanalysis, 8, 459-472.

Kallman, F. J. (1952). Comparative twin study on the genetic aspects of male homosexuality. Journal of Nervous Diseases, 115, 283-298.

Kardiner, A., Karush, A., Ovesey, L. (1959). A methodological study of Freudian theory III: narcissism, bisexuality, and the dual instinct theory. Journal of Nervous and Mental Disease, 129, 212.

Karr, R. (Aug 4th). Gay cure controversy, NPR, real audio recording. Retrieved Dec 30, 2001 from the World Wide Web: http://www.npr.org/news/health/970814.gay.html

Katz, J. (1976). Gay American history: lesbians and gay men in the U.S.A. (1st ed.). New York: Thomas Y. Cromwell.

Katz, J. (1996). The invention of heterosexuality. New York: Dutton.

Katz, J. N. (1983). Gay American almanac. New York: Harper.

Katz, M. S. (Dec 14, 1998). American psychiatric association rebukes reparative therapy. Retrieved Jan 1, 2001 from the World Wide Web: http://www.psych.org/news_stand/rep_therapy.html

Kennedy, I., Grubb, A. (1994). Medical law (2nd ed.). London: Butterworths.

Khan, M. (1964). The role of infantile sexuality and early object-relations in female homosexuality. In I. Rosen (Ed.), The pathology and treatment of sexual deviation: a methodological approach (pp. 221-292). New York: Oxford University Press.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E. (1953). Sexual behavior in the human female. Philadelphia: WB Saunders.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E. (1970). General Social Survey. New York: Basic Books.

Kinsey, A.C., Pomeroy, W.B., Martin, C.E. (1948). Sexual behavior in the human male. Philadelphia: WB Saunders.

Kirkpatrick, M. (1987). Clinical implications of lesbian mother studies. In E. Coleman (Ed.), Psychotherapy with homosexual men an women: an integrated identity approach for clinical practice (pp. 201-212). New York: Haworth.

Kirsch, J. A. W., Weinrich, J. D. (1991). Homosexuality, nature, and biology: is homosexuality natural? Does it matter?. In J. C. Gorsiorek & J. D. Weinrich (Eds.), Homosexuality: research findings for public policy. Newbury Park, CA: Sage.

Kite, M. E. (1994). When perceptions meet reality: individual differences in reactions to gay men and lesbians. In G. Greene, G.M. Herek (Ed.), Contemporary Perspectives in Lesbian and Gay Psychology, Vol. 1 (pp. 25-53). Newbury Park, CA: Sage.

Klein, F. (1978). The bisexual option: a concept of one hundred percent intimacy. New York: Arbor House.

Kleinman, A. (1980). Major conceptual and research issues for cultural (anthropological) psychiatry. Cultural Medical Psychiatry, 4(1), 3-13.

Kunkler, T. (2001, September). Price of progress: medical ethics and biotechnology. MD Net Guide, 3, 15-17.

Laan, E., Sonderman, J., Janssen, E. (1995). Straight and lesbian women's sexual responses to straight and lesbian erotica: no sexual orientation effects. In International Academy Of Sex Research (Ed.), 21st annual meeting. Provincetown, MA: IAOSR Press.

Lacquer, T. (1990). Making sex. Cambridge: Harvard University Press.

Lasch, C. (1992, August 10). For shame. The New Republic, 32, 20-22.

Laumann, E. O., Gagnon, J. H., Michael, R. T., (1994). The social organization of sexuality: sexual practices in the United States. Chicago: University Of Chicago Press.

Le Vay, S. (1996). Queer science: the use and abuse of research into homosexuality. Cambridge, MA: MIT Press.

Leibowitz, L. (1975). Evolution of sex differences. In R. Reiter (Ed.), Toward an anthropology of women (pp. 20-35). New York: Monthly Review Press.

Lerner, G. (1986). The creation of patriarchy. London: Oxford University Press.

Lever, J. (1994, August 23rd). Sexual revelations: the 1994 Advocate survey of sexuality and relationships: the men. The Advocate, pp. 17-24.

Levi-Strauss, C. (1969). In J. Bell & J. Von Strumer (Trans.) (Eds.), The elementary structure of kinship (p.). Boston: Beacon Press.

Lewis, H. B. (1971). Shame and guilt in neurosis. New York: International Universities Press.

Loewy, E. (1996). Textbook of healthcare ethics. New York: Plenum Press.

Lombroso, C. (1883). L'antisemitisme,2. Izdanje. Paris.

Lord Templeman (1985). Sidaway v. Bethlehem Royal Hospital Governors. In (Ed.), A.C. 871 (pp. 904-5). London: Judiciary Press.

Los Angeles County Health Services (June 15). Report of task force on runaway youth. Retrieved June 15, 2000 from the World Wide Web: http://lapublichealth.org/phdata1.htm

Loulan, J. (1986). Psychotherapy with lesbian mothers. In T. Stein & C. Cohen (Eds.), Contemporary perspectives on psychotherapy with lesbians and gay men (pp. 181-208). New York: Plenum.

Lyotard, J. (1984). The postmodern condition. In G. Bennington & B. Massumi (Trans.) (Eds.), A report on knowledge. Minneapolis: University Of Minnesota Press.

Marmor, J. (1980). Overview: the multiple roots of homosexual behavior, and epilogue: homosexuality and the issue of mental health. In J. Marmor (Ed.), Homosexual behavior: a modern reappraisal (pp. 3-504). New York: Basic Books.

Martin, D. (1984). The emperor's new clothes. In E. Hedrick & Terry Stein (Eds.), Innovations in psychotherapy with homosexuals (pp. 59-69). Washington, DC: American Psychiatric Press.

Masters, W., Johnson, V. (1979). Homosexuality in perspective. Boston: Little Brown.

Masters, W., Johnson, V., Kolodny, R. (1985). Human Sexuality (2nd ed.). Boston: Little, Brown.

Mattison, A. M. (1985). Group treatment of sexually compulsive gay and bisexual men. In A. M. Mattison (Ed.), Paper presented at annual meeting of the Eastern Region of the Society for the Scientific Study of Sex (pp. 2-5). Philadelphia.

Mayerson, P. & Lief, H. (1965). Psychotherapy of homosexuals: a follow-up study. In J. Marmour (Ed.), Sexual inversion: the multiple roots of homosexuality (pp. 1-12). New York: Basic Books.

Maylon, A. (1982). Psychotherapeutic implications of internalized homophobia in gay men. In J. C. Gonsiorek (Ed.), A practitioner's handbook of affirmative models (pp. 59-70). New York: Haworth.

Maylon, A. K. (1982). Psychotherapeutic implications of internalized homophobia in gay men. Journal of Homosexuality, 7, 59-69.

McConaghy, N. Proctor, D. Barr, R. (1972). Subjective and penile plethysmography response to aversion therapy for homosexuality: a partial replication. Archives of Sexual Behavior, 2, 65-78.

McDougall, J. (1970). Homosexuality in women. In J. Chassequet-Smirgel (Ed.), Female Sexuality (pp. 171-213). Ana Arbor, MI: Michigan University Press.

McIntosh, M. (1968). The homosexual role. Social Problems, 16, 182-192.

McLean, N. (1998, April 11,). Letter to the editor. The Globe and Mail, p. A1.

Mead, M. (1961). Cultural determinants of sexual behavior, in sex and internal secretions. Baltimore: Williams & Wilkins..

Menninger, K. (1963). Introduction. In Great Britain Committee On Homosexual Offenses & Prostitution (Eds.), The Wolfenden report (USA ed., pp. 1-13). New York: Stein & Day.

Mesnikoff, A. M., Rainer, J. D., Kolb, L. C. (1963). Intra-familial determinants of divergent sexual behavior in twins. American Journal of Psychiatry, 119, 732-738.

Meyer-Bahlberg, H. F. L. (1979). Sex hormones and female behavior. Archives of Sexual Behavior, 8, 101-120.

Meyer-Bahlberg, H.F.L. (1977). Sex horomones and male homosexuality in comparative perspective. Archives of Sexual Behavior, 6, 297-326.

Meyer-Bahlburg, H. F. L. (1984). Psycho-endocrine research on sexual orientation: current status and future options. Progressive Brain Research, 71, 375-397.

Michaels, S. (1996). The prevalence of homosexuality in the United States. In R. Cabaj, T. Stein (Ed.), Textbook of homosexuality and mental health (p. 43). London: American Psychiatric Press.

Missildine, W. H. (1963). Your inner child of the past. New York: Simon & Schuster.

Moberly, E. (1980). Homosexuality: a new Christian ethic. New York: Basic Books.

Money, J. (1987). Sin, sickness, or society? American Journal of Psychology, 42, 384-399.

Money, J. (1988). Gay, straight and in-between: the sexology of erotic orientation. New York: Oxford University Press.

Money, J. & Ehrhard, A. (1972). Man, woman, boy, girl. Baltimore: Johns Hopkins University Press.

Monroe, R. R., Enelow, M. L. (1960). The therapeutic motivation of male homosexuality. American Psychologist, 32, 629-637.

Morh, R. D. (1992). Gay ideas: outing and other controversies. Boston: Beacon Press.

Morison, A. (1825). Outlines on lectures on mental disease. In Richard Hunter & Ida Macalpine (Eds.), Three hundred years of psychiatry 1535-1860 (p. 773). London: Oxford University Press.

Morrison, A. P. (1989). Shame: the underside of narcissism. Hillsdale, NJ: Analytic Press.

Morrison, A.P. (1998). The culture of shame (2nd ed.). London: Jason Aronson Inc.

Murphy, T. F. (1992). Redirecting sexual orientation: techniques and justifications. Journal of Sexual Research, 29, 501-523.

Murphy, T.F. (1983). Freud reconsidered: bisexuality, homosexuality, and moral judgment. Journal of Homosexuality, 9(2/3), 65-77.

Murray, H. A. (1953). Explorations in personality. New York: Oxford University Press.

Myers, M. F. (1982). Counseling the parents of young homosexual male patients. In J. C. Gonsiorek (Ed.), Homosexuality and psychotherapy: a practitioner's handbook of affirmative models (pp. 375-398). New York: Haworth.

NARTH (National Association For Research And Therapy Of Homosexuality) (August). Bulletin excerpts. Retrieved June 15, 2000 from the World Wide Web: http://www.narth.com/mnus/bulletin.html

National Academies Of Science (November). Top news stories. Retrieved December 21, 2001 from the World Wide Web: http://www.nationalacademies.org/topnews/

National Association Of Social Workers (1997, August). Policy statement: psychiatric treatment and sexual orientation. Social Work Speaks, 4th, 20-25.

National Caucus For Lesbians, Gays, And Bisexuals (September). Position statement. Retrieved December 21, 2001 from the World Wide Web: http://www.the nationalinstitute.org/authenticity/

National Youth Advocacy Coalition (1988, June). Teen suicides. Bay Area Reporter, 34, 26.

Nicolosi, J (1991). Reparative therapy of male homosexuality. Northvale, NJ: Jason Aronson.

Nicolosi, J. (2000, June 27th). Homosexuality begins with a developmental disorder than can end with therapy. PCUSA News, p. 27.

Nietsche, F. (1882). Joyful Science. Stuttgard: Kroner.

Nietsche, F. (1887). Genealogy of morals. Stuttgart: Kroner.

Nietzche, F. (1901). The will to power (W. Kaufman translation). New York: Vintage Books.

Nietzsche, F. (1954). Thus spoke Zarathustra. In W. Kauffman (Ed.), The portable Nietsche (p. 378). New York: Viking.

Office Technology Assessment (October). Screening and testing. Retrieved December 21, 2002 from the World Wide Web: http://www.wws.princeton.edu/ota/ns20/alpha_f.html

Ovesey, L. (1969). Homosexuality and pseudo-homosexuality. New York: Science House.

Paglia, C. (1990). Sexual personae. New Haven: Yale University Press.

Parker, N. (1964). Homosexuality in twins: a report on three discordant pairs. British Journal of Psychiatry, 110, 489-495.

Parrinder, G. (1980). Sex in the world's religions. New York: Oxford University Press.

Pattison, E. M., Pattison, M. L. (1980). Ex-gays: religiously mediated change in homosexuals. American Journal of Psychiatry, 137, 358-362.

Paul, J. P. (1983). The bisexual identity: an idea without social recognition. Journal of Homosexuality, 9(2/3), 65-77.

Pellegrino, E. D., Thomasma, D. C. (1988). For the patient's good: the restoration of beneficence in health care. New York: Oxford University Press.

Pelligrino, E. D. (1993). The metamorphosis of medical ethics: a 30 year perspective. Journal of the American Medical Association, 269(9), 1158-1162.

Peplau, L. A., Amaro, H. (1982). Understanding the lesbian relationships. In J. C. Gonsiorek (Ed.), Homosexuality and psychotherapy: a practitioner's handbook for affirmative models (pp. 233-248). New York: Haworth.

Piers, G., Singer, W. B. (1971). Shame and guilt. New York: Norton.

Pillard, R. C. (1988). Sexual orientation and mental disorders. Psychiatric Annals, 18, 52-56.

Pillard, R. C. (1996). Homosexuality from a familial and genetic perspective. In Robert P. Cabaj & Terry S. Stein (Eds.), Textbook of homosexuality and mental health (pp. 350-359). Washington, DC: American Psychiatric Press.

Pillard, R. C., Poumadere, J. I., Carretta, R. A. (1981). Is homosexuality familial? A review, some data and a suggestion. Archives of Sexual Behavior, 10, 465-475.

Plomin, R., DeFries, J. C., McClearn, G. E. (1990). Behavioral genetics: a primer. New York: W H Freeman.

Plummer, K. (1975). Sexual stigma. London: Routledge & Kegan Paul.

Ponse, B. (1978). Identities in the lesbian world: the social construction of self. Westport, CT: Greenwood Press.

Puterbough, G. (1990). Twins and homosexuality: a casebook. New York: Garland.

Quanland, M. C. (1985). Compulsive sexual behavior: definition of a problem and an approach to treatment. Journal of Sexuality and Marital Therapy, 11, 121-132.

Radden, J. (2001). President's column. Bulletin: Association for the Advancement of Philosophy and Psychiatry, 9(1), 1-2.

Rado, S. (1940). A critical examination of the concept of bisexuality. Psychosomatic Medicine, 2, 459-467.

Rado, S. (1949). An adaptational view of sexual behavior. In P. H. Hoch & J. Zubin (Eds.), Psychosexual development in health and disease. New York: Grune & Stratton.

Rado, S. (1962). Psychoanalysis of behavior II. New York: Grune & Stratton.

Rainer, J. D., Mesnikoff, A., Klob, L. C. (1960). Homosexuality and heterosexuality in identical twins. Psychosomatic Medicine, 22, 251-259.

Reece, R. (1987). Causes and treatment of sexual desire discrepancies in male couples. In E. Coleman (Ed.), Psychotherapy with homosexual men and women: integrated identity approaches for clinical practice (pp. 157-172). New York: Haworth.

Rekers, G. A. & Kilgus, M. D. (2001, Dec 2001). Early identification and treatment of gender identity disorder. Psychiatric Times, XVIII, 44-50.

Rekers, G. A. (1995). Differential diagnosis and rationale for treatment of gender identity disorders and transvestism. In G.A. Rekers (Ed.), Handbook of child and adolescent sexual problems (pp. 124-135). New York: Lexington Books.

Rekers, G. A., Kilgus, M. D. (1998). Diagnosis and treatment of gender identity disorders in childhood and adolescents. In L. VanDeCreek, S. Knapp, T.L. Jackson (Ed.), Innovations in clinical practice: a sourcebook (pp. 44-55). Sarasota, Fl: Professional Resource Press.

Rice, G. P. (December). Preliminary study results. Retrieved January 14, 1998 from the World Wide Web: http://www.uwo.ca/cgi-bin/dsgw.pl

Rich, A. (1983). Compulsory heterosexuality and lesbian existence. Signs: Journal of Women in Culture and Society., 5, 631-660.

Richardson, D. (1983). The dilemma of essentiality in homosexual theory. Journal of Homosexuality, 9, 79-90.

Richardson, D. (1987). Recent challenges to traditional assumptions about homosexuality: some implications for practice. Journal of Homosexuality, 13(4), 1-12.

Ricoeur, P. (1992). In K. Blamey (Trans.) (Ed.), Oneself as another. Chicago: University Of Chicago Press.

1Rieber, I., Sigusch, V. (1979). Guest editorial: psychosurgery on sex offenders and sexual deviants in West Germany. Archives of Sexual Behavior, 8, 523-527.

Rieber, I., Sigusch, V. (1979). Guest editorial: psychosurgery on sex offenders and sexual "deviants" in West Germany. Archive of Sexual Behavior, 8, 523-527.

Rieff, P. (1966). The triumph of the therapeutic. New York: Harper & Row.

Rodman, H., Lewis, S. H., Griffith, S. B. (1984). The sexual rights of adolescents - competence, vulnerability, and parental control. New York: Columbia University Press.

Rogers, C. (1951). Client centered therapy. Boston: Houghton.

Rogers, P. (December). Letter to the editor. Retrieved December 19, 2001 from the World Wide Web: http://www.faithandvalues.com/channels/homosexuality.asp?source=overture

Rogers, S. M., Turner, C. F. (1991). Male-male sexual contact in the U.S.A.: findings from five sample surveys, 1970-1990. Journal of Sexual Research, (28), 491-519.

Romm, M. (1965). Sexuality and homosexuality in women. In J. Marmor (Ed.), Sexual inversion: the multiple roots of homosexuality (pp. 282-301). New York: Basic Books.

Ross, M. & Medelsohn, F. (1958). Homosexuality in college. AMA Archives of Neurological Psychiatry, 80, 253-263.

Ross, W. D. (1930). The right and the good. Oxford: Claredon Press.

Royal Society (September). Stem cell research. Retrieved Feb 5, 2002 from the World Wide Web: http://www.royalsoc.ac.uk/files/statfiles/documents-148.pdf

Rubin, G. (1975). The traffic in women: notes on the "political economy". In R. Reiter (Ed.), Toward an anthropology of women (pp. 157-210). New York: Monthly Review Press.

Rubin, G. (1984). Thinking sex. In C. Vance (Ed.), Pleasure and danger: exploring female sexuality (pp. 267-319). New York: Routledge.

Rubenstein, G. (1995). The decision to remove homosexuality from the DSM: twenty years later. American Journal of Psychotherapy, 49, 416-427.

Rust, P. C. (1993). Coming out in the age of social constructionism: sexual identity formation among lesbian and bisexual women. Gender and Society, 7, 50-77.

San Francisco Examiner (1989, June 6,). Results of a poll. San Francisco Examiner, A19.

Sartre, J. P. (1956). Introduction to being and nothingness. In H.E. Barnes (Ed.), Being and nothingness (pp. 221-222). New York: Philosophical Library.

Saslow, J. (1986). Ganymede in the renaissance. New Haven: Yale University Press.

Satinover, J. (2001). Homosexuality and the politics of truth. New York: Basic Books.

Schippers, J. (1989). Homosexual identity, essentialism and constructionism in homosexuality. In D. Altman, C. Vance, M. Vicinus, J. Weeks (Ed.), Homosexuality, which homosexuality (p. 1989). London: GMP Publishers.

Schmalz, J. (1993, March 5,). Poll finds even split on homosexuality's cause. The New York Times, p. A14.

Schmidt, G. (1984). Allies and persecutors: science and medicine in the homosexual issue. Journal of Homosexuality, 10, 127-140.

Schmidt, G., Schorsch, E. (1981). Psychosurgery of sexually deviant patients: review and analysis of new empirical findings. Archives of Sexual Behavior, 10, 301-323.

Schneider, C. D. (1977). Shame, exposure and privacy. Boston: Beacon Press.

Schoeder, M, Shidlo, A. (January 12, 2002). Follow up: psychologist says efforts to 'cure' homosexuality can cause lasting damage. Retrieved January 12, 2002 from the World Wide Web: http://detnews.com/voices/price/970926/970926.htm

Schoen, M. (Jan 2002). Bisexuality. Retrieved 02/02/02 from the World Wide Web: http://www.intimacyintitute.com/sex_data/topics/bi.html

Seattle Commission On Children And Youth (July 15). Report of the commission. Retrieved June 15, 1998 from the World Wide Web: http://www.cityofseattle.net.mayor.news.asp

Sedwick, E. (1993). Tendencies. Durham: Duke University Press.

Sergent, B. (1986). In A. Goldhammer (Trans.) (Ed.), Homosexuality in Greek myth. Boston: Beacon Press.

Sheraton, A. (1980). Foucault: the will to truth. London: Tavistock.

Shields, S. A., Harriman, R. E. (1984). Fear of male homosexuality: cardiac responses of low and high homo-negative males. Journal of Homosexuality, 10, 53-67.

Siegel , E. (1988). Female homosexuality: choice without volition. Hillsdale, NJ: Analytic Press.

Sigusch, V., Schorsch, E., Dannecker, M. (1982). Official statement of the German Society for Sex Research on the research of Prof. Dr. Gunter Durner on the subject of homosexuality. Archives of Sexual Behavior, 11, 445-449.

Silverstein, C. (1981). Man to man: gay couples in America. New York: William Morrow.

Silverstein, C. (1988). The borderline personality and gay people. Journal of Homosexuality, 15, 185-212.

Silverstein, C. (1996). History of treatment. In Robert P. Cabaj & Terry S. Stein (Eds.), Textbook of homosexuality and mental health (pp. 3-11). Washington, DC: American Psychiatric Press.

Singer, M. B. (1953). Shame cultures and guilt cultures. New York: Norton.

Sintchak, G., Geer, J. A. (1975). A vaginal plethysmograph system. Psychophysiology, 12, 113-115.

Slimp, J. C., Hart, B. L., Goy, R. W. (1978). Heterosexual, auto-sexual, and social behavior of adult male rhesus monkeys with medial pre-optic anterior hypothalamic lesions. Brain Research, 142, 105-122.

Smith, J. (1988). Psychopathology, homosexuality and homophobia. In M. W. Ross (Ed.), Psychopathology and psychotherapy in homosexuality (pp. 177-185). New York: Haworth.

Socarides, C. (1968). The overt homosexual. New York: Grune & Stratton.

Socarides, C. (1969). Psychoanalytic therapy of a male homosexual. Psychoanalytic Quarterly, 38, 173.

Socarides, C. (1970). Homosexuality and medicine. Journal of the American Medical Association, 212, 1201.

Socarides, C. (1972). Homosexuality- basic concepts and psychodynamics. International Journal of Psychiatry, 10, 121.

Socarides, C. (1974). Homosexuality. In Silvano Arieti (Ed.), American handbook of psychiatry (2nd ed., p. 291). New York: Basic Books.

Socarides, C. (1975). Beyond sexual freedom. New York: Quadrangle Books.

Socarides, C. (1978). Homosexuality. New York: Aronson.

Somit, A. (1968). Brainwashing. In D. Solls (Ed.), International encyclopedia of the social sciences (pp. 139-143). New York: Macmillian.

Spira, A., Bajos, N., Bejin, A. (1993). Les comportements sexuels en France. Paris: La Documentation Francaise.

Spitzer, R. (June 19). Much ado about changing. Retrieved January 15, 2002 from the World Wide Web: http://www.advocate.com/html/stories.840/840_spitzer.asp

Stampfl, T. G. & Levis, D. J. (1967). Essentials of implosive therapy. Journal of Abnormal Psychology, 72, 496-503.

Standing Committee On Human Affairs (1994). Report of the standing committee on human affairs of the Episcopal Church to the general convention. Retrieved 12/21/2001 from the World Wide Web: http://www.ai.mit.edu/people/mib/anglican/official/humaff

Stein, T. (1984). Social constructionism and essentialism: theoretical and clinical considerations relevant to psychotherapy. Journal of Gay and Lesbian Psychotherapy, 2, 83-99.

Stein, T. (1992). Forms of desire. New York: Routledge.

Stein, T. (1996). A critique of approaches to changing sexual orientation. In R. Cabaj And T. Stein (Ed.), Textbook of homosexuality and mental health (pp. 525-535). Washington, DC: American Psychiatric Press.

Stekel, W. (1922). Psychosexual infantilism. Vienna: Urban & Schwarzenberg.

Stekel, W. (1930). Is homosexuality curable? Psychology Review, 17, 443-451.

Stoller, R. J., Herdt, G. (1985). Theories of origins of homosexuality. Archives of General Psychiatry, 42, 399-404.

Stoller, R.J. (1980). Problems with the term "homosexuality". Journal of Clinical Psychiatry, 2, 3-25.

Stone, A. (2002, January). The WPS's declaration of Madrid has no foundation in traditional medical ethics. Psychiatric Times, 1, 3-4.

Storms, M. D. (1980). Theories of sexual orientation. Journal of Personality and Social Psychology, 38, 783-792.

Swaab, D. F., Hoffman, M. A. (1990). An enlarged supra-chiasmic nucleus in homosexual men. Brain Research, 537, 141-148.

Thorpe, J. (1992). Adult refusal of treatment. All E.R., 4, 649.

Thorpe, J. (1994). Adult: refusal of medical treatment. All E.R., 6, 819.

Throckmorton, W. (1998). Attempts to modify sexual orientation: a review of outcome literature and ethical issues. Journal of Mental Health Counseling, 20, 283-304.

Tiefer, L. (1992). Social constructionism and the study of human sexuality. In Stein, E. (Ed.), Forms of Desire (pp. 295-324). New York: Routledge.

Troiden, R. R. (1988). Gay and lesbian identity. Dix Hills, NY: General Hall.

Trumback, R. (1989). Gender and homosexual role in modern western culture: the 18th and 19th centuries compared. In R. Trumbach (Ed.), Homosexuality, which homosexuality (pp. 149-169). London: GMP Publishers.

U.S. Department of Health and Human Services (November). Report on Suicide. Retrieved December 21, 2001 from the World Wide Web: http://www.hhs.gov/news/press/1993/20020516.html

Van Baal, J. (1993). The dialectics of sex in Marind-anim culture. In G. Herdt (Ed.), Ritualized homosexuality in Melanesia (2nd ed., pp. 128-166). Berkeley: University Of California Berkeley.

Van Den Aardweg, G. (1997). The battle for normality. San Francisco: Ignatius Press.

Vance, C. S. (1989). Social construction theory: problems in the history of sexuality. In D. Altoman, C. Vance, M. Vicensu, J. Weeks (Ed.), Homosexuality, which homosexuality? (pp. 13-34). London: GMP Publishers.

Von Krafft-Ebing, R. (Ed.). (1901). Psychopathia sexualis (translation of 10th German edition) (3rd ed.). Chicago: WT Keener.

Wallace, L. (1969). Psychotherapy of a male homosexual. Psychoanalytic Review, 56, 346-354.

Washington Post (May 22nd). Human Cloning. Retrieved February 5, 2002 from the World Wide Web: http://www.washingtonpost.com/wp-dyn/articles/A61636-2001May22.html

Weeks, J. (1977). Coming out. London: Quartet Books.

Weeks, J. (1977). Coming out: homosexual politicos in Britain from the nineteenth century to present. London: Quartet Books.

Weeks, J. (1985). Sexuality and discontents. London: Routledge & Kegan Paul.

Weeks, J. (1985). Sexuality and its discontents. New York: Routledge.

Weinberg, G. (1972). Society and the healthy homosexual. New York: St. Martin's.

Weinberg, M. S., Williams, C. J. (1974). Male homosexuals: their problems and adaptations. New York: Oxford Press.

Weinberg, T. (1984). Biology, ideology, and the reification of developmental stages in the study of homosexual identities. Journal of Homosexuality, 10(3-4), 77-84.

Weis, C.B., Dain, R.N. (1979). Ego development and sex attitudes in heterosexual and homosexual men and women. Archives of Sexual Behavior, 8(4), 341-356.

1Wellings, K., Field, J., Johnson, A. (1994). Sexual behavior in Britain: the national survey of sexual attitudes and lifestyles. London: Penguin.

West, D. J. (1977). Homosexuality re-examined. Minneapolis: Minnesota Press.

Whitehead, H. (1981). The bow and the burden strap: a new look at institutionalized homosexuality in native North America. In S. B. Ortner & H. Whitehead (Eds.), Sexual meanings (pp. 80-115). Cambridge: Cambridge University Press.

Whitener, R. & Nikelly, A. (1962). Sexual deviation in college students. American Journal of Orthopsychiatry, 34, 427-439.

Whitman, F. L., Mathy, R. M. (1986). Male homosexuality in four societies: Brazil, Guatemala, the Philippines, and the United States. New York: Praeger.

Williams, W. (1986). The spirit and the flesh. Boston: Beacon.

Winkler, J. (1990). The constraints of desire. New York: Routledge.

Wittig, M. (1992). The straight mind. Boston: Beacon Press.

Wolpe, J. (1969). The practice of behavioral therapy. New York: Pergamon Press.

Wood, F. W. (Ed.)(1990). An American Profile: Opinions and Behavior 1972-1989. Detroit: Gale Research.

Working Party Of The British Medical Association (1986). The torture report. London: BMJ Publishing.

World Medical Association (1975). Declaration of Tokyo. Washington, DC: WHO.

Wright, T. N. (1999, June). Suicide. Bay Area Reporter, p. 13.

Zucker, K. J., Bradley, S. J. (1999). Gender identity disorders and transvestic fetishes. In S.D. Netherton, D. Holmes, C. E. Walker (Ed.), Child and adolescent psychological disorders: a comprehensive textbook (pp. 233-239). New York: Oxford University Press.

Additional reference:

Tong, R. (1997). Feminist Approaches to Bioethics: Theoretical Reflection and Practical Applications. Westview Press, Portland, OR.